CMP
Chemist & Druggist
12 February 2005

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Review suggests three devolved RPSGB boards

LIFT pharmacies merely 'income generators' fear

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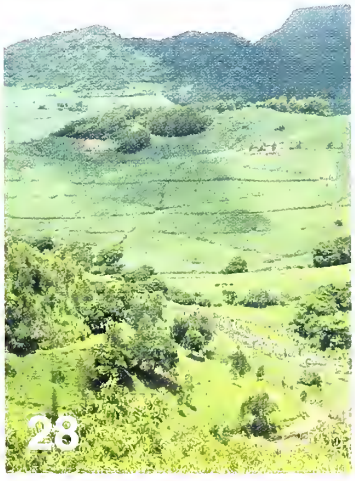

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OTC prices may sway contract decisions

PCTs will be forced to give priority to contract applications by pharmacies offering cheaper OTC medicines if legislation is passed amending the control of entry regulations.

Department of Health community pharmacy policy manager Peter Dunlevy has said that, as a concession to the Office of Fair Trading, the DoH will be pushing to put through legislation requiring PCTs to consider the availability of cheaper OTC medicines as a way of deciding between two equal applications for a new pharmacy contract. This will be done as soon as Parliamentary time allows, he said at a PCT training event on the reforms to the control of entry regulations.

His comments come in light of the 2003 OFT report, which highlighted that opening up the pharmacy market could lead to improved access to cheaper OTC medicines. Mr Dunlevy said: "We will consider enabling PCTs to take into account, when assessing applications, the improvements they would bring to the provision of, or access to, over the counter medicines."

LPC representatives who were present at last Monday's National Primary and Care Trust Development Programme conference have slammed the way the DoH unveiled the news as unbelievable. Kensington, Chelsea & Westminster LPC secretary Rekha Shah said: "This is not the right way to say something like this. This should have been part and parcel of the original documents, so we could have discussed this properly."

Ms Shah warned that the new proposals could favour the multiples, and will be difficult to police. "I can understand access to cheaper medicines being taken into account but is it fair that a multiple is able to put an independent pharmacy under pressure (even contribute to its demise) only for company policy on medicines pricing to change six months later. These issues need to be discussed now," she said.

PSNC, which was also present at the conference in London, confirmed that such a change could be on the cards, but downplayed the urgency of the situation. PSNC head of regulation Stephen Lutener said: "The DoH has been open about the importance of the recommendations made by the Office of Fair Trading and it is likely that one day it will look again at the OFT's recommendations. At that point it will have to go out to consultation, giving us an opportunity to respond – but this could be some time away."

Commenting on the potential impact on the independent sector, John D'Arcy, NPA chief executive, said NHS services should not be about price competition. "It is not whether a pharmacy is large or small that is important but whether it is good and we do not believe that it is right for PCTs to interfere in aspects of pharmacy business that are not NHS pharmaceutical services," he said.

"However, attitudes to OTC medicines are shifting, and self-care is now becoming part of NHS pharmaceutical services. In this context, it is right that PCTs should get involved in minor ailment schemes.

"The issue now is how the new test of choice and competition will be implemented in practice. The tests of choice and competition must not be allowed to frustrate the principle test of necessary or desirable, so the guidance will be critical," he added.

Nucare has also expressed concern over the proposals. Managing director Mahesh Shah said: "This approach is fraught with difficulties, including the sustainability of such an approach and whether it encourages the safe and appropriate use of medicines. In our view, if you want to encourage self-medication, then removing the VAT is one way to achieve this." **AC**

RPSGB short of members

Three thousand more pharmacists needed to register with the RPSGB if it were to avoid a financial shortfall, treasurer John Jolley told Council last week.

By February 9, the Society said 40,534 pharmacists had now renewed their membership. Of these 35,003 registered as practising, 5,531 as non-practising and 2,050 had retired from the Register. This still leaves a shortfall of just under 1,000 members needing to register if the Society's budget projections are to be met. **AF**

Conservatives condemn Government position on screening tests in pharmacies

Earl Howe, the Conservative health spokesman in the Lords, has criticised the Government for not taking a stronger lead on offering screening tests as part of an expansion of pharmacy services.

Following Earl Howe's question in the Lords on what plans Government has to encourage screening in pharmacies, health minister Lord Warner promised to write to him with the Government's views on the expansion of services.

Lord Warner said at the time that the Government was considering how to use screening as one of the new duties that pharmacies undertake.

But Earl Howe was disappointed when he received the letter, a copy of which was obtained by *C&D*, as it did not commit the Government to "upgrading" screening from local enhanced services to essential services any time in the near future.

Earl Howe said: "I had hoped for something more. I hoped it would say that the Government was driving forward public health issues from the centre, not leaving it up to PCTs. This was a golden opportunity for the Government to say to me at the dispatch box: 'We are going to take a lead on this'.

"Public health can't be totally devolved to PCTs. They should be the vehicles that take forward initiatives that mostly come from Whitehall.

"I was very disappointed by the content [of the letter] but especially by the tone and its lack of urgency." **VM**

"Typical! All I wanted was a big packet of THOSE NEW MANGO CONDOMS and they've sold out again."

RPSGB review proposes split into national boards

by Adrienne de Mont

A devolution review group has recommended that the RPSGB's Council should have national boards for England, Scotland and Wales.

This should overcome resentment in Scotland and Wales that decisions were being made in Lambeth, as if "what's good for England is good for Great Britain," said Lord Fraser of Carmyllie QC, chairman of the RPSGB's devolution review group.

He told Council last week that health policies in the devolved countries were diverging from those in England, so there should be a much clearer separation of exclusively English issues from GB issues.

Increased powers for the Scotland and Wales boards would give them more influence with local policy-forming organisations, as they would be able to react faster to consultations than if they had to wait for Council decisions.

The group, mostly comprising Council members, had little difficulty in concluding that the Society should devolve power where issues were exclusive to one country, but acknowledged there could be problems if issues arose in one country that could have clear GB implications, such as the abolition of prescription charges in Wales.

Lord Fraser said the group did not try to cost the proposals. Some financial burden would move from Lambeth to Edinburgh and Cardiff, but this could be offset by Scotland and Wales being able to make their own decisions.

There was a strong feeling that disciplinary regulation should remain a GB issue to ensure consistency, and that the Statutory Committee or its successor should continue to sit in Lambeth. The common core of undergraduate and pre-registration education should also remain a GB function, but there could be variations in postgraduate education and training in the different countries.

Stressing that the report was not an attempt to dictate how Council should organise its affairs, Lord Fraser said: "We've tried to set up a relatively straightforward structure for the Society in England, Wales and Scotland. We're not trying to bulldoze you into an early decision."

Council has asked for an implementation plan to be drawn up for its next meeting in April.

Inbrief

Contract toolkit

AAH is launching a three-tier toolkit to help pharmacists deliver services in the new pharmacy contract.

The kit, which should be available before April, is to help with staff training and updated medicines management services, which are now compliant with the new Medicines Use Review template. Only available to AAH customers, the pack is expected to cost under £120. A guide to applying for enhanced service funds from PCTs is being developed. AAH has also launched a free consultation room blueprint to support pharmacists who wish to add this feature.

For more information:
Vantage Pharmacy Team
Tel: 02476 432000

Chair debate

The Royal Pharmaceutical Society's Council has agreed to spend £5,500 on planning to accommodate the future Council.

The current Council chamber at the Society's headquarters in London is designed to seat 26, and will be inadequate for the 30-strong Council that will come into existence in May. The funds will be spent on investigating whether refurbishing the existing chamber or developing other Society space are viable options.

SPGC update

The Scottish Pharmaceutical General Council says ceftazidime powder for injection 500mg, 1g and 2g, and Telzir oral suspension have been added to the Scottish *Drug Tariff* zero discount list.

Also, due to stock shortages, SPGC says endorsements for chloramphenicol eye ointment and penicillamine tablets 250mg will be accepted during February.

Pharmacy seen as 'income generator' for NHS LIFT

by Gary Paragpuri

Pharmacy has been relegated to the status of income generator in the NHS LIFT concept rather than being seen for its clinical input, a director of a pharmacy multiple involved in the scheme has reported.

The benefits to local people "seem to be overshadowed by the need for developers to make a commercial profit", David Vanns, operations director at Weldricks, has said.

LIFT should in theory improve premises, consolidate health services and provide an opportunity for PCTs to make the most of local contractor services, said Mr Vanns. But instead the scheme was including pharmacies on the basis of them paying a "hefty premium and above market rent".

Furthermore, PACT data was being used to calculate LIFT rents, which meant they were based on prescription volume rather than the serviced-based healthcare proposed in the forthcoming new pharmacy contract, he said.

Mr Vanns highlighted a current LIFT project in which Weldricks is part of a consortium with two other contractors. Despite making it clear to the developer and PCT that the contractors were committed to a consortium to ensure patients received the best level of services, Mr Vanns said the developer had requested exclusive bids from the three contractors for sole occupation of the LIFT pharmacy.

"Clearly companies will act in the best interests of their business and, as they are not members of the primary healthcare team, we can hardly be surprised if property developers act purely commercially.

"Pharmacy, we are continually being told, is in a partnership of health providers and is needed to play a key role in primary healthcare. Pharmacy has a lot to contribute to the partnership, but, LIFT, like other areas of community based healthcare provision, seems to be another occasion where we are invited along because of what we can be made to pay, rather than because of the pharmaceutical expertise we can contribute," he said.

Mr Vanns made his comments after last month's opening of a Weldricks pharmacy in the Goldthorpe LIFT centre in Barnsley.

Barnsley LPC secretary Keith Mitchell said the LPC was involved at an early stage to make sure local pharmacies were given first option on the contract but it was excluded as soon as money became an issue.

Mr Mitchell said Barnsley was fortunate in that the nearest local contractors to the LIFT scheme were multiples and they could afford the "apparently unrealistic rents. Presumably if local pharmacies could not afford the rent, the LIFT scheme would look outside the local area for a pharmacy partner," he added.

Health minister Rosie Winterton launched a free organ donor Valentine's card in a Co-op pharmacy in Southampton this week. She was joined by Debra Collier, who has been waiting for a donor kidney for nine years. The free Valentines organ donor cards were produced in conjunction with UK Transplant and to participants from over 300 Co-op pharmacies. Pictured, from left, are Liz Collins, Co-op member pharmacy owner, Debra Collier and Rosie Winterton

LEGAL

SOS and RPSGB agree reduction in legal costs

The four Save Our Society campaigners who lost their legal challenge against the RPSGB submitting a new Charter for approval have agreed legal costs with the Society.

Hassan Argomandkhah, Mark Koziol, Graham Phillips and Mike Williams must pay £255,000, some £81,492 less than the original claim. The SOS four have already paid £150,000, leaving a balance of £105,000 to be paid by March 6. Including their own legal costs, the SOS four's total costs will be over £300,000.

An SOS spokesman said they had received donations of £82,000 towards the costs, but he appealed for further help.

An RPSGB spokesman, when asked about the shortfall from its original claim, said the Society was covered by insurance.

Further, the insurance company had been involved from the outset and the RPSGB had renewed the policy without an increase in the premium, the spokesman added.

Pharmacists wishing to make a donation to the SOS can pay directly to its bank account at: SOS Campaign, Bank of Scotland, sort code 80-02-22, and account no 00109606. **GP**

WHOLESALERS

Pharma stop supplies to some short-liners

Two pharmaceutical companies have stopped supplying ethical products to some short-line wholesalers.

Pfizer and Lilly's decision has made it "very difficult" to get hold of their parallel import products, Sigma Pharmaceuticals managing director Bharat Shah said. Pharmacists' discount clawback assumes PIs are being used, so restricting availability may result in retailers losing money, he warned.

Mr Shah said he did not know why the companies had decided to restrict distribution, guessing they wanted to control product numbers and distribution. But he added: "If companies try to stop competition at a distribution level, it will lead to monopolies and drug price increases."

Lilly spokesman Andrew Day said the company had conducted a review of its overall wholesaler network, looking at the company's current needs and future product portfolio, and had closed accounts with some short and full-line suppliers.

But he added: "We are confident all retail pharmacists will be able to get Lilly products through the wholesaler network."

Pfizer confirmed it had discontinued direct accounts with some UK wholesalers, saying: "This change in our supply system was made in order to rationalise our supply accounts, increase business efficiencies whilst ensuring sufficient supplies of medicines to our UK customers." **AF**

Questiontime

This week's question:

OTC medicine prices could influence pharmacy contract applications. What do you think?

- It's good for patients
- Smaller pharmacies will lose out
- The contract wouldn't have been OK'd, if we'd known
- The NHS should keep its nose out of retailing

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Reference: 1. Strecher V *et al.* Poster presented at the 12th World Conference on Tobacco or Health, Helsinki, 3-8 August, 2003

POLITICS

Minister wants regulator's decisions to be more open

by Vikki Miller

The public have been kept in the dark about the decisions behind drugs licensing, health minister Lord Warner admitted last week.

More work needs to be carried out on the public register and publication of clinical trials to make the Medicines and Healthcare products Regulatory Agency's decisions more transparent, the minister said.

"It is not in anybody's interest to create a climate where the regulator's decisions are placed in doubt. We need to get a better public understanding of these hard decisions made," he told a Common's select committee investigating the influence of the pharmaceutical industry.

In an attempt to reduce the number of harmful medicines approved by the MHRA, the health minister said the DoH is considering a new proposal to grant a provisional licence after the third clinical trial stage. A fourth set of clinical trials would then be carried out to monitor the new drug among a large group of patients before it receives full approval.

Dr June Raine, post licensing division head at the MHRA, agreed with MPs that the current Yellow Card system needed improvement, stating it would be more successful if a larger number of cards were received from a wider range of professions, including pharmacists and patients.

But she added that the new initiative for patients to directly fill in Yellow Cards had begun well. She said: "We have had 35 reports from patients since January 17."

Lord Warner acknowledged that current patient information leaflets were "not perfect" and cited new European legislation, due to come into force this July, which dictates that the leaflets should be produced with increased patient involvement.

But the minister denied that stricter regulation would encourage the pharmaceutical industry to innovate an increased number of "original" medicines, as opposed to more "me-toos", and announced a new initiative to stimulate innovation, the Futures Forum. This will be set up to take a holistic look at where to concentrate future R&D time and money.

Lord Warner was also quick to rebuff MPs' suggestions that the competitive aspects of his current role be moved to the Department of Trade and Industry, stating that it would create departmental conflicts. He also rejected ideas of a government-funded MHRA because it would cause a backlog of licensing applications due to depleted funds. He did, however, agree to look into suggestions that the advisory committees sit in public, as they do in the USA.

Lord Warner gave evidence at the final session for the health select committee investigating the influence of the pharmaceutical industry. Recommendations are due to be released late March.

POLICY

Bids open for chlamydia screening in pharmacies

The Department of Health is inviting healthcare providers to submit bids to pilot free chlamydia screening in community pharmacies in London and Cornwall.

The pilots will target 16 to 24-year-olds, including the partners of those testing positive, and could also offer patients the choice of receiving treatment at their local pharmacy. Adverts inviting expressions of interest will appear from February 10 and bids will be assessed on the basis of clinical quality, accessible facilities, turnaround times and use of technology.

The Government pledged £80 million to fund a nationwide chlamydia screening programme in November, in the White Paper on public health. Currently there are 26 programmes, covering one in four English PCTs.

Announcing the initiative, public health minister Melanie Johnson said: "It's vital that we make it easier for young men and women to get tested for chlamydia ... pharmacists are already in position on the high street to provide NHS quality chlamydia testing. This means costs to the taxpayer are kept down and we won't need to draw on staff from other areas of the NHS."

The pilot will be monitored and evaluated over a two-year period and, if successful, could then be rolled out nationally. **AC**

Picture: Novartis Visions of Science 2003/Lisa Barnard

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UniChem challenge stalls EAP and Phoenix merger

UniChem has mounted a legal bid to force the Office of Fair Trading to rethink its decision to allow Phoenix Healthcare to merge with East Anglian Pharmaceuticals. Phoenix and EAP have put their merger plans on hold.

Calling for the OFT's decision to be quashed, UniChem says there are four grounds for the challenge. It says that:

- The OFT's decision not to refer was irrational and unjustified and a misconstruction or a misapplication of its duty.
- Given the serious competition concerns identified by the OFT, its reasons for not referring the merger were insufficient and did not dispel the serious likelihood of a substantial lessening of competition.
- There are a number of unresolved issues of material fact outstanding, including the constraining effect of other full-time wholesalers; market share and market concentration issues; the distinction between dispensing doctors and pharmacies and the competitive constraint offered by Phoenix.
- The OFT failed to take adequate account of its previous decisions.

A spokesman for UniChem said that the company believed that Phoenix's acquisition of EAP raised serious competition issues, particularly in relation to concentration of supply in the region, and that the OFT should have referred the matter to the Competition Commission for a thorough investigation.

"The OFT referred AAH's attempted acquisition of EAP in 2003 and considers that the issues in this case are very similar. An acquisition of EAP by Phoenix will be bad for competition because it means less choice for pharmacists and dispensing doctors based in the region."

The OFT made its initial decision about Phoenix's proposed acquisition on December 17, after concluding that a merger would not be expected to result in a substantial lessening of competition, due to the presence of short-liners and AAH and UniChem in the region. The Competition Appeal Tribunal, which hears challenges of this type, is expected to hear the case on Monday.

Although under no requirement to do so, EAP and Phoenix have decided to await the final outcome of the challenge before pursuing merger plans.

Phoenix chief executive David R Cole said: "We believe the OFT made its decision on the back of full and accurate market information, including the full-line competition in the area. UniChem's move is frustrating for us and for EAP, which is being prevented from developing its business. We are surprised that UniChem has appealed and think its grounds are questionable." **AC**

Evercare scheme doubts

The Evercare model for case management is unlikely to cut emergency hospital admissions of older people by anything more than 1 per cent, an independent review of the scheme has revealed.

This comes in sharp contrast to evidence from the USA, where the scheme reduced emergency admissions of older people by 50 per cent.

But emergency admissions among high-risk elderly patients in the UK are likely to decline anyway, even without the nurse-led programme, researchers said.

The review, commissioned by the DoH and carried out by a consortia of academic institutions, tracked hospital admission rates among older patients to see if they decreased when patients were cared for under the Evercare scheme.

Despite concluding that the programme may not be as effective as first thought, the study found that Evercare did improve the patients' quality of life and that patients gave favourable reports of their experiences. **VM**

Lord Newton of Braintree has been awarded honorary fellowship of the RPSGB. Nicholas Wood, RPSGB president, highlighted Lord Newton's contributions to health and public life, and to the work of the Society through his role as its parliamentary adviser

PRACTICE

'Treat diversity uniformly' plea

Pharmacy must ensure it has a uniform approach to addressing diversity, Royal Pharmaceutical Society vice-president Hemant Patel has said.

The Society's Council should develop a policy that will affect all areas of practice, including the interface between pharmacists and patients. This will help improve concordance by looking at issues such as labelling medicines in different languages, and prescribing for patients who fast for religious reasons, said Mr Patel at last week's Council meeting. **AF**

WHOLESALERS

Nucare rejigs sales force

Nucare has announced a reorganisation of its sales force to better support its members ahead of the new pharmacy contract.

The main areas of focus for the restructured sales force are:

- expanding the Nucare Plus and Branding programmes
- increasing Nucare membership and usage of its preferred suppliers
- managing the professional services support offered by Nucare.

The company is considering an advertising campaign for its contract services. **AF**

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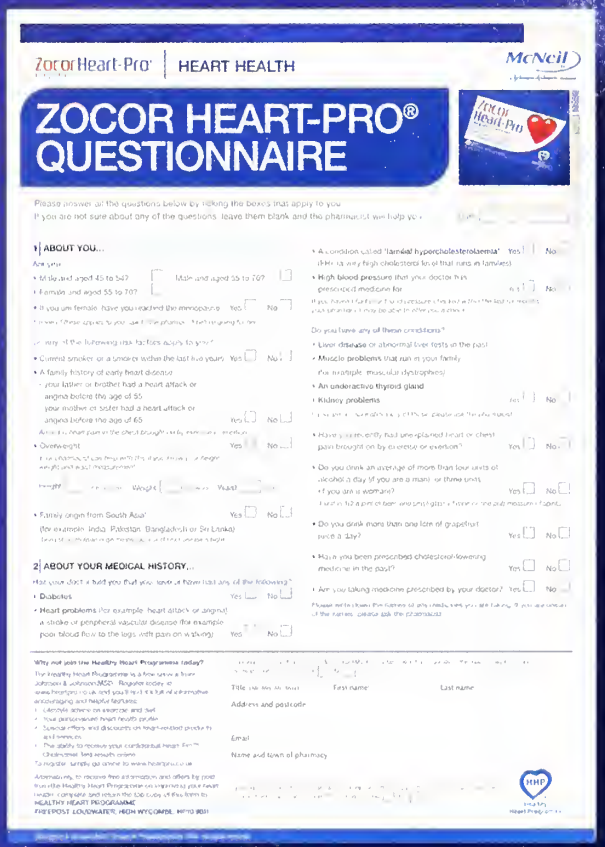
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- A Female aged 55 to 70?
- If you are female, have you reached the menopause? Yes No

Do any of the following risk factors apply to you?
- Current smoker or a smoker within the last two years Yes No
- A family history of early heart disease
  - your father or brother had a heart attack or angina before the age of 55
  - your mother or sister had a heart attack or angina before the age of 65 Yes No
- Overweight Yes No
- Family origin from South Asia Yes No
  (for example: India, Pakistan, Bangladesh or Sri Lanka)

2 ABOUT YOUR MEDICAL HISTORY...

Has your doctor ever told you you have had any of the following?
- Diabetes Yes No
- Heart problems (for example: heart attack or angina)
- A stroke or peripheral vascular disease (for example poor blood flow to the legs, often pain on walking) Yes No

A condition called 'familial hypercholesterolaemia' Yes No
(this is any high cholesterol (or of that runs in families)
- High blood pressure that your doctor has prescribed medicine for Yes No

Do you have any of these conditions?
- Liver disease or abnormal liver tests in the past
- Muscle problems that run in your family (for example: muscular dystrophies)
- An underactive thyroid gland
- Kidney problems Yes No
- Have you recently had unexplained heart or chest pain brought on by exercise or exertion? Yes No
- Do you drink an average of more than four units of alcohol a day (if you are a man) or three units (if you are a woman)? Yes No
- Do you drink more than one litre of grapefruit juice a day? Yes No
- Have you been prescribed cholesterol-lowering medicine in the past? Yes No
- Are you taking medicine prescribed by your doctor? Yes No

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ZOC140

In brief

Lloyds promotion

Lloydspharmacy has announced that Nick Mortimer (pictured) has been promoted to superintendent pharmacist.

Pharmacy director Andy Murdock, the former title holder, will now focus on Government relations and new business development, says the company.

Mr Murdock said he was delighted about Mr Mortimer's appointment, adding: "It is an increasingly demanding position and now requires the sole attention of one committed individual and his team."

ABPI award

The Association for British Pharmaceutical Industry has invited entries for the 2005 ABPI annual pharmacy award from practising pharmacists who innovate and improve their services.

The award is designed to recognise "innovative pharmacy practice that brings benefits to patients". This could be through improving medicines' use, prescribing or dispensing quality, or developing services to offer patients access to high quality pharmaceutical care and medicines.

Application forms can be obtained from the ABPI's website, *www.abpi.org.uk*, and should be sent to Martin Anderson, *manderson@abpi.org.uk*, by April 30, 2005.

Oxygen audit

Pharmacists have until April 1 to complete an audit of their oxygen cylinders and reconcile any missing supplies with BOC, PSNC has said.

The original February 1 deadline has been extended by two months following negotiations between PSNC, BOC and the DoH. An announcement on the future provision of domiciliary oxygen services is expected before the end of the month, PSNC added.

Cash for asthma

The Conservative Party has pledged £30 million to help asthma sufferers if it wins the next general election.

Asthma sufferers would benefit from an adequate number of trained respiratory staff, be able to access NICE standards of care, and have personal care plans drawn up by their GP. This would be funded as part of the extra £34 billion the Tories have pledged to invest in the NHS by 2009-10.

CCA COMMENT

The brave new world of ETP

Colin Baldwin, chief executive of the Company Chemists' Association, sets out what will be needed for electronic transfer of prescriptions to succeed

The development of pharmacy computing systems and their integration into the wider NHS network are of fundamental importance to the delivery of the new contract and community pharmacy's evolution as a provider of primary care services.

Integration is essential to give pharmacists and other health professionals electronic access to information about dispensing, advice, prescription interventions and medicines utilisation reviews.

Electronic transfer of prescriptions is an important first step in this process but there are a number of important principles CCA believes need to apply to system design and operation.

1. Unfettered freedom of choice

Government policy clearly signals that it wants to maximise choice for patients. This must remain so for ETP. Patients' ability to freely nominate a pharmacy of their choice to receive their prescriptions will be fundamental, as will the need to allow flexibility to change the nominated pharmacy, to temporarily suspend a nomination, eg when on holiday, or to choose not to nominate a particular pharmacy at all. Choice and flexibility will be compromised if GPs are able to influence choice or nominate a pharmacy on behalf of their patients.

2. Access to appropriate clinical information

There are obvious benefits to patient safety from pharmacists providing a fully informed professional input into the supply and management of medication, using appropriate information from the patient's computer record. There is still uncertainty over what information pharmacists and their staff will have access to – and this has to be clarified. Now that GPs no longer have a monopoly over primary care provision (and others shoulder the responsibility of patient care during the out-of-hours period), it

is essential that access to patient records is on the basis of clinician need and not limited on the basis of historical precedent.

3. Effective contingency planning

It goes without saying that it will be crucial to the operation of all community pharmacies that ETP systems are robust, resilient and reliable. If prescriptions can only be received electronically, transmission failures will mean that prescriptions cannot be accessed, no dispensing can occur and patient care will be compromised. Contingency plans are essential.

4. A level playing field during roll out

Care and thought needs to be given to the transitional period for ETP implementation. It is essential that there is a level playing field within prescribing and dispensing communities during roll out to ensure that everyone has an equal opportunity to prepare for and provide the service from day one.

There are, nevertheless, clear benefits for patients, community pharmacy and the NHS. It is the first step in a long overdue process that will see pharmacy integrating with primary care information systems. The CCA welcomes the development and looks forward to working with all stakeholders.

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Strawberry flavour

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Dealing with parallel trade

Delegates from the pharmaceutical industry and regulatory authorities met last week to discuss parallel trade, reports **Asha Fowells**

Parallel importing is an issue that is not going to go away, so all involved must learn to deal with it. This was the message from British Association of Pharmaceutical Wholesalers technical director Tony Garlick at last week's *Parallel Trade and the Pharmaceutical Industry* conference organised by the Management Forum training company.

Governments will not do anything about parallel trade because the practice encourages competition between suppliers, Mr Garlick said. But he added that the number of products available as PIs was likely to fall as more drug patents expired and generic versions were launched.

The recent Pharmaceutical Price Regulation Scheme agreement to reduce branded medicine prices by 7 per cent would also impact on parallel import levels, Mr Garlick said. Manufacturers had reduced the prices of some commonly imported products significantly so they were now cheaper than the corresponding PIs, he explained.

Janice Haigh of IMS Health described how UK parallel trade growth had slowed from a 44 per cent increase between 2000-01 to around 11 per cent from 2003-04. This was due to the types of products targeted by parallel importers. In 2002, 12 products accounted for half of all PIs, yet in 2005 17 products made up 50 per cent of PIs, she said.

This showed that parallel traders were having to target smaller, non 'blockbuster', products. In addition, manufacturers were adopting different stock management strategies so there was less surplus stock available for parallel trade, Ms Haigh explained.

Price difference is not the driver for parallel trade, she added. Germany, for example, has higher drug prices than the UK, but a lower level of PIs, and has only recently introduced incentives for pharmacists to use them. The UK has higher PI usage because of the way pharmacists and wholesalers are remunerated, she said.

Other factors affecting each country's parallel trade level are the difference between a product's list and import price; product equivalence; product availability; supply chain issues; and regulatory and legal requirements. Ms Haigh added that though there was some evidence of drug price convergence in Europe, a single drug price applicable in all EU states was not possible, so parallel trade would not stop.

Birmingham pharmacist John Ryan explained that drug costs comprise 98.6 per cent of NHS prescription payments. "So pharmacists must reduce the cost of the drug as much as possible by using PIs or generics," he said.

Tony Garlick: parallel imports encourage competition between suppliers

Pharmacists use many sources to find out about new PIs, Mr Ryan told delegates. These include the pharmacy computer system, drug company and wholesaler representatives, price lists and other pharmacists. But not all products would be of interest, he said, citing price, availability, usage, packaging, presentation and generic availability as factors.

Although patients had been initially reluctant to accept PIs, they had become "resigned" to getting different packs, Mr Ryan said. Now the main issue was that many PI packs still showed the product's British Approved Name (BAN), though European law dictated that packs should feature the Recommended International Non-proprietary Name (rINN) for medicinal substances.

All parallel importers met the standards set by the Medicines and Healthcare products Regulatory Agency, Mr Ryan said, adding: "PIs are very well regulated in the supply chain and I have no problem using them." But he warned that drug prices were going to be addressed in the new *Drug Tariff* and, if margins dropped, there would be less incentive for pharmacists to buy PIs.

Nick Beckett of law firm CMS Cameron McKenna outlined the legal differences between different forms of repackaging: over-labelling, the least intrusive form, involves the importer placing a label over the manufacturer's original packaging; de-branding to remove all manufacturer's marks; co-branding by adding the importer's mark alongside the proprietor's; and re-boxing.

Intellectual property lawyer Anna McKay said legislation stating that medicines' packaging must feature the product name in Braille is due to come into effect on November 1. This may mark the end of over-labelling, as covering Braille with a second Braille label in a different language could be dangerous, she warned.

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[1] A & Riley E. The effect of Clitstim (Vielle) on sexual response induced by masturbation in female volunteers. Sexual and Relationship Therapy, ...

Comment from the Editor

Our question to pharmacists this week was:
A Labour MP proposed a red triangle on drug labels to highlight the risk of drowsiness when driving. Is this a good idea?

"Yes, it would associate with other signs in the Highway Code"

Edmund Pereira, Hertford

"They should get that advice when it is dispensed, but we should be doing that anyway"

Natasha Deitsch, Borehamwood

Our online poll at *www.dotpharmacy.com* said...

65% A good idea

19% Too confusing for the patient

16% Wrong, they get that info when a drug is dispensed

Can the Department of Health be trusted? An official has suggested that legislation will allow a PCT to make a decision based on who sells the cheapest over the counter medicines when faced with several applications which are otherwise equally valid to open a new pharmacy.

This is unwise. It smacks of misaligned priorities, of a Government meddling in affairs that are none of its business (but the business of pharmacists), of a Government that knows the price of everything and the value of nothing.

Despite its professed reliance on pharmacy's contribution, this sudden interest in the cheapest OTC medicines devalues the pharmacists' advice. And if reimbursement is to be squeezed further, just how does the DoH expect small pharmacies to survive?

Resale price maintenance has gone, and despite the best efforts of the large retailers, customers still buy OTC medicines at their local pharmacy because they see the value in the pharmacy service as a whole. How much more competition can the DoH really expect?

If it really wants to increase access to self-care, it could set up more patient group directions or abolish the prescription fee. How about ending the 'black list' of medicines banned on NHS prescription? Oh sorry, that would actually put some of the risk back on the Government.

This recent expression of a 'cheap as chips' approach to healthcare is worrying. It has not been helped by the dearth of legislative detail for the new contract. Pharmacy contractors may well worry about what they have signed up to, especially as the 'balanced package of measures' is due for review in 2006.

While few PCTs will be faced with such a decision, this is a dangerous principle, raising concerns about what remains undisclosed.

"How about ending the 'black list of medicines banned on NHS prescription?"

Yourviews

E-mail your views to chemdrug @ cmpinformation.com

Peter Curphey, an Isle of Man pharmacist, replies to Graham Phillips

Silence is golden ...

Having read the letter from Graham Phillips (*C&D, January 22, p16*), I wondered if there is anyone else tired of hearing from him?

He seems determined to blame everyone else for the Council's shortcomings rather than taking any corporate responsibility. He seems also to have forgotten that anything wrong with the output from Council must be, in some measure, down to him.

Instead of that, in my opinion he deliberately repeats the misleading conclusion that making membership protection an upfront object of the Society has in some way changed the Royal Charter and done us all a service.

It must have come to his notice that the Shipman reports have made it clear that special pleading for members of a profession rather than regarding public interest protection as our prime objective is not the flavour of the month.

Keeping quiet now would be really useful, though I suspect that his and other's behaviour over the past year may well have been noticed; as election time is on us it will surely continue.

The fact is, any suggestion that we see pharmacy as a special case, and do not need to take the view that our prime responsibility is to the public, will be dealt with harshly. We may yet see pressure for the very split which he and his supporters claim not to want.

Meanwhile he might like to reflect that all you have to do on the Council to "change the world" is to get another 12 members to agree with you and the conspiracy will be dealt with.

That he cannot get this done suggests that not quite as many of the Council agree with his views as he would have us believe.

Come on Mr Phillips, just do something for the public interest and then our profession will reap the rewards.

HOSPITAL REPORT

How safe are our working hours?

The headline on the cover of the January 29, 2005 issue of *C&D* leapt out at me: "RPSGB to look into pharmacy work pressures." Great! Some acceptance of the stresses within the system which could compromise patient safety.

Imagine my disappointment, then, to read that it only applied to community pharmacies. I fully agree that the work is necessary. I have worked in pharmacies similar to those mentioned by David Morgan in the article which prompted the review. However, there could hardly have been a better time to consider pressures within the managed service too.

For too long hospital pharmacies have relied on staff goodwill to ensure that the work is completed. Rarely has increased workload been met with an increase in staff. Only when new services have been introduced, or existing services extended, has this been a possibility.

It has all now come home to roost. The acceptance of the pay modernisation package, *Agenda for Change*, has reduced the working week for pharmacists from 39 to 37.5 hours with immediate effect. A recent survey carried out by NHS management two or three days before Christmas identified only two health board areas where there were problems. The timing and tight deadline for return shows how seriously it was considered.

For too long hospital pharmacies have relied on staff goodwill

Now, all those pharmacists who have been working 45/46 hours a week to keep the service afloat are starting to revolt. Unless action is taken quickly, some hospital pharmacy services are likely to fall apart. Watch out for shrapnel!

Written by a senior hospital pharmacist

TOPICAL REFLECTIONS

Out of the picture again over co-proxamol

It was lucky I was watching the news the other evening or I wouldn't have known that co-proxamol was being withdrawn. As it was, I found out the same information and at the same time as the rest of the general public. Well done to the RPSGB's David Pruce for publicly criticising the MHRA for not informing healthcare professionals earlier.

I knew this was on the cards but was unable to give patients any more details than they already knew. I was surprised by how many turned up with bags full of co-proxamol for disposal, keen to get rid of drugs that they had not been taking for some time. With that much of the stuff tucked away in medicine cabinets no wonder it is an easy option for the suicidal.

I was also rather surprised that some patients returned current medication saying that the pain that the co-proxamol was originally prescribed for had long since disappeared. They simply kept taking the tablets because they kept appearing on their repeat prescription.

There will also be a collection of die-hards insisting they must still have their favourite painkiller because nothing else works, and I don't look forward to convincing them that the withdrawal was made in everyone's best interest.

More haste, less speed for IT changes

Apparently I could be receiving and transmitting electronic prescriptions this summer (*C&D, February 5, p9*). This is like saying that I'll have reached the top level of the latest Playstation game by the summer, but I won't be able to practise or even be told the rules until five minutes beforehand.

The NPfIT's frantic pace of implementation is frightening, if not downright unrealistic. How am I going to make plans for purchasing, training, installation and operation of a system that hasn't even been designed yet? And I guess the reason that it hasn't been designed is that the NPfIT has rushed the computer companies as badly as it plans to rush me.

The computer companies are promising to be ready in time, but I'm not sure what they will be ready with. What on earth is a smart code reader, and will it fit into my dispensary? With multiple terminals and assorted gadgets, my dispensary may start to look more like a flight deck than a healthcare operation.

I'm sure all this equipment will be very impressive and fun for the technically minded, but to my mind it's a lot of stuff to go wrong. And if this kit goes wrong I won't be getting any prescriptions. And worse still, if I can't transmit to the PPA I won't get paid. If the whole N3 network goes down patients will be queuing out of the door of every pharmacy in England waiting for their virtual prescriptions.

I know that all pharmacies will be in the same boat over this, but I just hope that I'm one of the last pharmacies in the ETP roll-out so I've had some time to prepare and the experts have ironed out at least some of the problems.

Bell's Health Care – Correction

In our issue of 22 January 2005 under the heading "Coughing up confusion", *Xrayser* criticised Bell's Health Care for the inclusion on its pholcodine linctus label of a warning against its use by epileptics. *Xrayser* said such a warning was incorrect and suggested that Bell's "must be playing it safe to guard against potential lawsuits, rather than acting on clinical information". *Xrayser* contrasted the Bell's label with Numark's label which he said did not include a warning to epileptics.

Xrayser was wrong to criticise Bell's. The warning on its pholcodine linctus is correct and is a requirement under the relevant EU guidelines.

We apologise to Bell's Health Care for our error.

E-mail your views to chemdrug@cmpinformation.com

LIFT concerns echo views of NPA members

David Vanns' comments (*see p6*) echo those we receive on a regular basis from members who are being forced into relocating their pharmacies into, or adjacent to, new surgery developments.

Such relocation provides the opportunity for closer professional working with GPs. But this comes at a price. Negotiation with property developers results in resources being sucked out of pharmacy in the payment of premiums and a rental which in most cases far exceeds market value.

This is a direct consequence of a system that sees pharmacists remunerated for dispensing prescriptions rather than for their emerging clinical role. So, pharmacists stand apart from other healthcare professionals and are perceived as 'cash cows' rather than legitimate healthcare players.

A new contract has just been negotiated with the Department of Health which will provide a framework for a revised system of remuneration aligned more closely to their clinical role. It will also see a tighter fit with the planning processes of PCTs and encourage greater collaborative working with other healthcare professionals – particularly GPs.

This is actually what LIFT projects are designed to do. They are intended to get primary care professionals working together to improve patient care and to allow PCTs to get the best out of local contractor services. Unfortunately for community pharmacy, this seems to translate into being forced into paying excessive rents rather than investing in better patient care.

To this extent, therefore, LIFT projects seem to be out of kilter with the way local contracts are being adjusted to assure the delivery of high quality patient focused care.

At a time when pharmacists should be dedicating their energies to working with GPs, other healthcare professionals and PCTs in agreeing strategies for integrated healthcare solutions, they are instead haggling over the rent.

The new contract is all about the provision of a patient focused service and funding has been agreed on the basis of the cost of providing this service and fair return. And to ensure fairness, PCTs need to play a more active role in integrating pharmacists into local development plans on equal terms with other health professions.

The NHS desperately needs to make best use of limited resources. Community pharmacy has the ability to pay a handsome return on the investment now being made in it. But this investment must be placed in new and improved services and not frittered away by lining the pockets of property developers.

We are concerned about the impact of primary care estate developments on the pharmacy network and will continue to make these concerns known to the Department of Health and PCTs. Meanwhile, we have a number of resources available for members including *Understanding Primary Care Estate Strategy*, *Working with NHS LIFT* and *Consortium Pharmacies*. I would urge any member needing help or advice to contact the NPA.

John D'Arcy
chief executive, NPA

Is it time for a judicial review?

"Those whom the gods wish to destroy they first make mad." This is my description of the Royal Pharmaceutical Society.

For the past year I have resisted writing to the *Journal* – partly because I could not understand the irrelevant content and partly because I was appalled at the agenda of the members of Council, which was apparent to me, having been a member of Council for 20 years.

My Society granted me a membership and a fellowship, which I was delighted to receive. Now as a non-practising member, they have been totally negated as I can no longer give any advice on healthcare and medicines.

My 40 years on the Register practising the profession have been totally disregarded. I doubt that I can even advise on the sale of 16 paracetamol without first stating that I am a "non-practising pharmacist," although I could of course send the questioner to the nearest petrol station to buy them.

What am I going to tell my friendly GP when he asks for some simple information, eg the dosage of Exerol 75mg?

Talk about bringing the profession into disrepute! This is the first time I can recall being alongside Peter Curphey, but I have to admit that he has got it right this time.

As a compromise surely we could change "non-practising" to "non-dispensing" and allow a substantial proportion of our members to offer their advice to patients. It is not too late to avoid destroying the profession.

The problem started with PIANA (Pharmacy in a New Age) in 1996, followed by the work of members of staff – aided and abetted by the Department of Health.

I believe that Lambeth has a number of ex-DoH staff working for the Society. Few of these have any experience of the community sector. Instead they have galloped into CPD and are in danger of destroying the profession.

We would do well to remember that pharmacy will only survive as long as it provides a service that patients require. We do not offer the profession for the benefit of the DoH but for patient care.

The mess we are in today is the result of the belief that our future lay with the DoH. We have lost sight of the reason for our existence – patient care.

Having re-read this letter with the dreaded "non-practising" clause, the situation is worse than I had realised.

The final sentence means that I will not represent myself (even accidentally) at any time as a practising pharmacist. My hard-earned Fellowship would also seem to be at risk.

This crazy situation must be stopped now. As a matter of urgency, we must call another general meeting to seek leave to apply for a judicial review to stop this nonsense.

Graham Walker FRPharmS
Totnes, Devon

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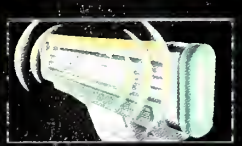

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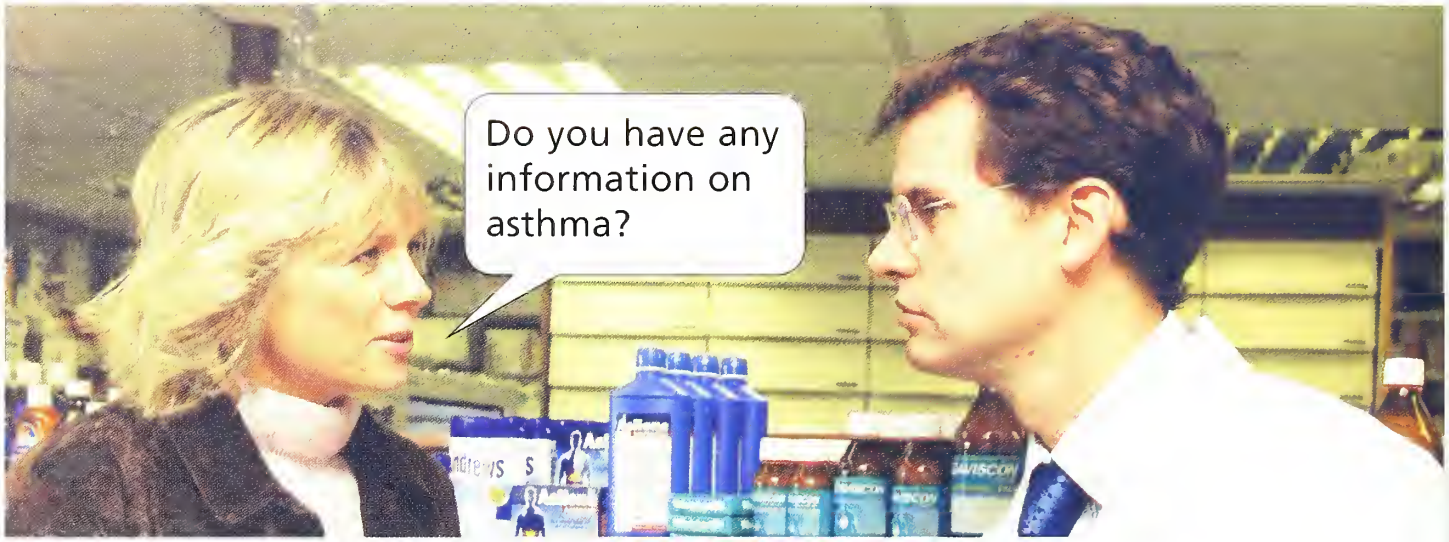

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CPD

This article can help in the following areas of competence as set out in the RPSGB's CPD manual: **G1, G7, C25.**

Mary Allen FRPharmS describes two patients with restless leg problems

Legs on the go

THE COLLEGE OF PHARMACY PRACTICE

This course (module 1327), in association with multiple choice questions being published in *C&D* March 5, provides one hour's continuing education

Learning

- To know the possible causes of restless legs and akathisia
- To know the difference between the two conditions
- To be aware of other disorders with similar symptoms
- To be aware of possible treatments
- To know what self-help measures to advise

Case study: Mrs Weir

Mrs Weir, a 62-year-old woman, visits your pharmacy for some advice. She feels so tired and is having problems with her legs. They "have bothered her for a while but are getting worse".

Every evening, when sitting watching television, she gets a "crawling" sensation – "almost as though insects are crawling about" inside her legs. She finds it hard to sit still and the only relief comes with walking about. The symptoms often stop her from sleeping. Can you suggest anything that might help?

Mrs Weir's patient medication record indicates that she is taking atenolol, lisinopril and aspirin 75mg. You ask her if she has any other symptoms or whether she is taking any OTC medicines. She tells you she is sometimes short of breath.

Symptoms

Restless legs syndrome (RLS) is a disorder that can affect sleep, sometimes profoundly. In severe cases the resulting sleep deficit may affect work, social and domestic life and general quality of life. RLS may also cause discomfort during waking hours and lead to an inability to sit for long periods. It usually affects both legs, but can occur in one leg only. Some patients also have symptoms in their arms or other body parts.

RLS is usually progressive, but remission sometimes occurs. It tends to affect people in middle or older age, but can affect younger people too.

Karl Ekbom, a Swedish neurologist, first used the term restless leg syndrome in 1944, and the syndrome is sometimes called Ekbom's disease. He was not the first doctor to describe the condition, which had been documented around 300 years earlier by Thomas Willis, a 17th century English physician who served King Charles II.

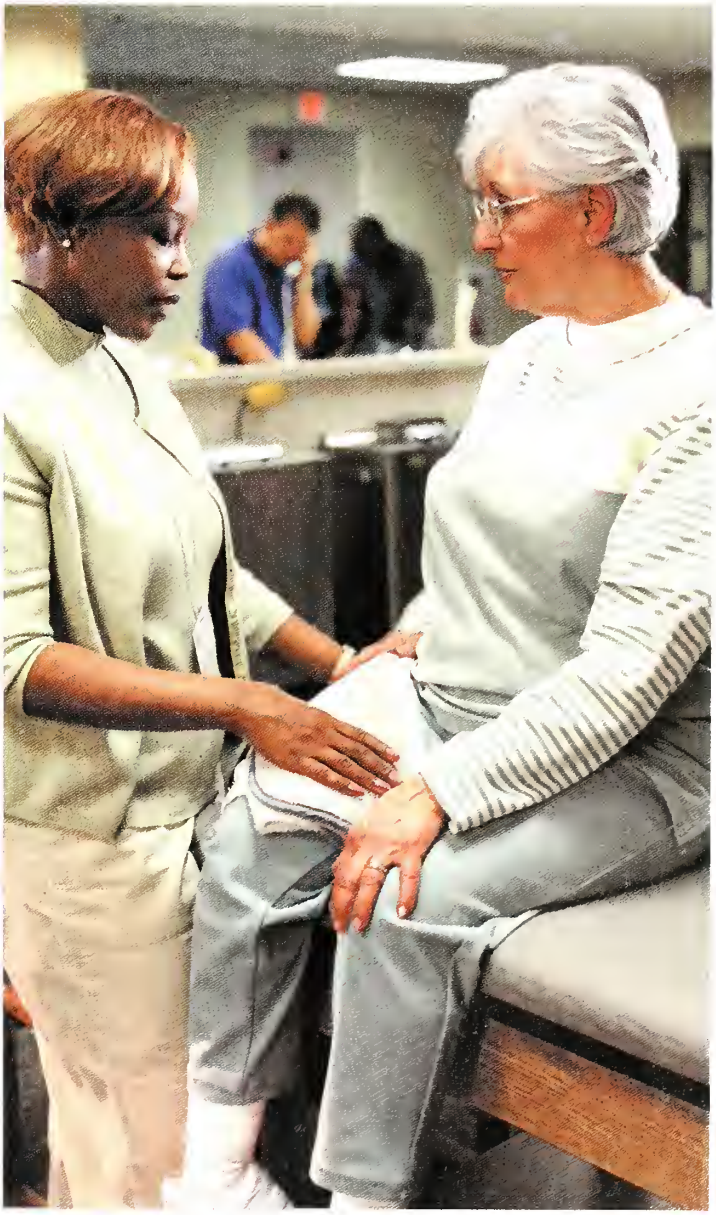
Four criteria for RLS

- An irresistible need to move the legs. This is usually because of, or accompanied by, uncomfortable sensations including burning, pain, tickling or crawling sensations, numbness or weakness. The sensations feel as though they are coming from within the legs. The need to move sometimes occurs without these uncomfortable sensations.
- The symptoms occur or worsen during periods of rest or inactivity, such as lying or sitting still.
- The symptoms are partially or totally relieved by movement, such as walking or stretching, but may return on resting.
- The symptoms are worse (or only occur) in the evening or at night.

How common is it?

RLS is common and is probably under-diagnosed. Ten to 15 per cent of the population may have the condition and it is probably the most common movement disorder. Although many patients

Continued on page 22 ▶



Sufferers from restless leg syndrome often describe their symptoms as feeling similar to a "crawling" sensation from within the legs themselves

may have a mild form, around a fifth of sufferers may have symptoms that are severe and disabling, requiring specialist treatment.

Who does it affect?

The majority of patients have primary RLS of unknown cause. Although most patients first present with symptoms in middle age, symptoms may date back to childhood when they may have been wrongly diagnosed as "growing pains" or "hyperactivity". Prevalence increases with age.

RLS often runs in families and seems to be more prevalent in women than men. In some cases, it occurs secondary to another condition. RLS is sometimes associated with iron deficiency anaemia. It can affect those with end stage renal disease (ESRD), particularly dialysis patients.

Between 15 and 25 per cent of pregnant women are affected with symptoms of RLS, usually in the third trimester of pregnancy. Symptoms, which usually resolve a few weeks after childbirth, may be due to reduced levels of serum ferritin (stored iron) or serum folate, and treatment is not usually necessary.

Studies have shown that the lower the levels of serum ferritin, the more severe the symptoms. An MRI study found reduced concentrations of iron in specific brain areas (the *substantia nigra* and *putamen*) in patients with RLS compared with controls, and there was a relationship between the degree of deficiency and the severity of symptoms, suggesting that iron insufficiency may play an important role in RLS.

Patients with chronic diseases such as diabetes, rheumatoid arthritis, Parkinson's disease or peripheral neuropathy may also suffer with RLS.

What causes it?

RLS is thought to be a disorder involving several CNS neurotransmitter systems, including some dysfunction of the dopaminergic system. The endogenous opioid system may be involved, as opioids have been found to benefit some patients. Underactivity of the GABA and serotonin neurotransmitter systems may also play a role.

The disorder tends to run in families so there is thought to be a genetic component. RLS has been associated with certain other conditions, which if treated brings about an improvement in the symptoms of RLS. For example, correcting an iron, vitamin B_{12} or folic acid deficiency can ease symptoms. Nerve damage associated with rheumatoid arthritis, kidney failure or diabetes may also play a part.

RLS may be caused or exacerbated by various drugs such as diuretics, and some people think stimulants like caffeine or decongestant drugs may make matters worse. Some antidepressants may exacerbate RLS and the antidepressant mirtazapine lists restless legs as a rare side effect (*see also drug-induced akathisia below*).

Differential diagnosis of RLS

Some other disorders with similar symptoms to those experienced in RLS include:

- Nocturnal leg cramps
- Drug-induced akathisia
- Vascular disease (including varicose veins and intermittent claudication)
- Arthritis related pain and discomfort of legs
- "Growing pains" or hyperactivity in children
- Anxiety or generalised anxiety disorder

Self-help measures for RLS

Preventing or reducing symptoms

- Use sleep hygiene measure to improve sleep (*see box below*)
- Avoid sitting or standing for long periods
- Stay cool and comfortable – wear loose clothing and use light bedding

Managing symptoms

- Go for a walk
- Stretch the legs
- Massage the legs
- Have a warm bath
- Do some relaxation exercise such as yoga or meditation

Sleep hygiene

- Reduce caffeine intake, especially from lunchtime onwards
- Increase exercise in the daytime, but not near bedtime
- Avoid cat naps in the daytime if sleep is a problem at night
- Reduce alcohol intake, especially late at night
- Have a warm milky drink at bedtime
- Have a warm bath at bedtime
- Avoid intellectual or stimulating work late in the evening

Diagnosis

There is no specific diagnostic laboratory test for RLS. Diagnosis is reached through recognising characteristic symptoms in combination (*see box*) and by investigations and examinations to rule out other possibilities such as vascular causes. Secondary causes such as iron deficiency anaemia, vitamin B_{12}/folate deficiency, diabetes mellitus and kidney failure should be excluded.

Patients with severely disrupted sleep caused by RLS may be referred for studies of sleep patterns in specialised centres.

Treatment

Treatment usually involves advice on self-help measures and encouragement of a regular sleep routine.

Any possible causes, such as iron deficiency anaemia, should be identified and treated. Correction of iron or vitamin deficiency is important as it is thought that up to one third of elderly patients with RLS can benefit in this way.

If medication for other conditions is potentially responsible, then stopping the treatment or changing over to an alternative is appropriate.

No drug is currently licensed for the treatment of RLS. However, studies have indicated that dopamine agonists such as ropinirole, pergolide, or cabergoline taken in the evening may improve the symptoms. Nausea and headache seem to be the worst short-term side effects.

Over the longer term, however, although many patients continue to benefit and sometimes need dose increases, some patients taking dopamine agonists seem to suffer with augmentation of RLS symptoms. Researchers are looking at ways of predicting patients at higher risk of this problem.

How can you help Mrs Weir?

You can reassure Mrs Weir that, however unpleasant her symptoms are, the condition is not dangerous. You can give her advice about self-help measures and about sleep hygiene.

It is unlikely that her drugs are exacerbating her RLS. Mrs Weir's tiredness may simply be related to lack of sleep caused by the symptoms. However, she may be anaemic. Her breathlessness needs investigating: this plus her tiredness could indicate anaemia. If so, improving her iron levels may improve her RLS. She should discuss these issues with her GP.

Akathisia: drug-induced restlessness

Some drugs, particularly some antipsychotics, can cause akathisia, a disorder causing restlessness differing from RLS in that it can occur at any time of day. Although frequently referred to as a movement disorder, the motor restlessness is often accompanied by symptoms of anxiety, dread, dysphoria, or agitation, which may be mistaken for further deterioration of illness rather than a drug-induced adverse drug reaction. If due to an antipsychotic drug, this may lead to an increase in the dose, which just makes matters worse.

The word akathisia comes from the Greek meaning "not to sit". Akathisia is an important potential side effect to remember in patients prescribed antipsychotics, anti-emetics, or antidepressants, but is often not recognised.

The causative drug (or drugs) should be withdrawn if possible, or the dose(s) reduced. Alternatively a switch to another drug may help, eg to an atypical antipsychotic such as olanzapine if an antipsychotic is the cause, or another anti-emetic as appropriate. If this is not possible, propranolol can be useful in treating the symptoms. Some patients may respond to an antimuscarinic drug such as procyclidine.

Akathisia is thought to be more likely to occur if a second drug is

introduced in a patient already taking a drug with this potential. Although this may seem like carelessness on the part of the prescriber, it is not an uncommon scenario. An example is a psychiatric illness where an antipsychotic may be prescribed for someone already taking an antidepressant. It could also occur where a patient already on an SSRI antidepressant is subsequently prescribed metoclopramide as an anti-emetic. In palliative care, haloperidol or metoclopramide may be prescribed as anti-emetics for frail patients on antidepressants, who may also be burdened with impaired liver or renal function, adding to the likelihood of side effects.

Case study: Mrs Jones

Mr Jones is picking up his wife's prescription and asks if he can have a word. Mrs Jones hasn't been well recently and has been suffering with depression for some time. In fact she is reluctant to leave the house, which is why he is collecting her medicines.

More recently she has been feeling nauseous. The doctor prescribed some medicine but now she is very restless, pacing about all the time. He doesn't know if it's her "nerves" getting worse, or whether it is something else. A neighbour mentioned a condition called restless legs – could this be what Mrs Jones is suffering from? Can he buy any medicines over the counter that might help?

Correcting an iron, vitamin B_{12} or folic acid deficiency can ease symptoms so supplements may be recommended if necessary

You remember that Mrs Jones is quite small and elderly. From her PMR you can see she has been taking sertraline for nearly a year, starting on 50mg daily and increased to 100mg daily. Recently she has been prescribed metoclopramide 10mg three times daily.

It is highly likely Mrs Jones's restlessness is akathisia caused by metoclopramide, especially taken in conjunction with an SSRI. The GP should be consulted about the possibility of stopping the metoclopramide. If this drug has caused the problem, Mrs Jones should be told her restlessness and pacing isn't due to her "nerves".

As she is sensitive to the drug, she should avoid it in future. The GP may also wish to review her depression and drug treatment, particularly as it doesn't seem to be improving.

Mary Allen is a part-time community pharmacist and hospice pharmacist in Herts.

Some drugs which may cause akathisia

Antipsychotics	Particularly haloperidol
Anti-emetics	Metoclopramide, prochlorperazine
Antidepressants	Tricyclics, selective serotonin reuptake inhibitors (fluoxetine, paroxetine, sertraline), venlafaxine
Calcium channel blockers	Possibly diltiazem
Others	Cinnarizine, methyldopa, levodopa and sometimes dopamine agonists Possibly: lithium, buspirone, some anticonvulsants, pethidine, interferon alfa, sumatriptan

Information sources for RLS

- RLS:UK is a multidisciplinary group working with the Ekbom Support Group. *www.restlesslegs.org.uk*
- The Ekbom Support Group is a patient group for people with RLS. *www.welcome.to/ekbom*

Actionplan

1. Read the online article in *Medscape* entitled *A practical approach to recognising and managing restless legs syndrome* by Anil N Rama and Clete A Kushida (*www.medscape.com*), then complete the assessment section.
2. Can you identify any of your patients suffering from restless legs syndrome? If so, ask them about their symptoms. Investigate the history of their disease. Does it mirror the article?
3. What other condition is related to problems with the *substantia nigra*? Is there any link between this and RLS?
4. Check the side actions of all the drugs in sections 4.2 and 4.3 of the *British National Formulary* to establish which cause RLS. Try to discover why mirtazapine causes this problem.
5. Try to find out more about sleep hygiene.

Distance learning for pharmacists

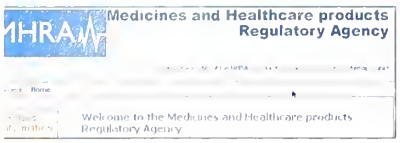
Pharmacists using **Pharmacy Update** for continuing education are reminded of the need to test. With the support of Genus Pharmaceuticals, *C&D* readers can self-test their progress by using the multiple choice question (MCQ) paper to be inserted in the March 5 issue, which will cover this week's CPP-accredited module, together with those in the February 19 and 26 issues. These will cover:

- **Restless legs (1327)**
- **Endocannabinoids (1328)**
- **Hepatitis (1329)**

A telephone marking service offers independent verification of results – details on the monthly MCQ papers. People wanting to register for Pharmacy Update can contact Mary Prebble on 01732 377269.

in association with GP

GENUS PHARMACEUTICALS



Strattera advice

The Medicines and Healthcare products Regulatory Agency has issued advice for prescribers and patients on the use of Strattera (atomoxetine).

The advice follows a Committee on Safety of Medicines review that found evidence of a link between atomoxetine and rare, but sometimes severe, liver reactions. Around 10,000 UK patients have been treated with the attention deficit hyperactivity disorder drug since it was launched last July.

In a letter to healthcare professionals, CSM chairman Professor Gordon Duff said the risk was estimated at less than one in 50,000 patients treated. Routine liver function monitoring is not recommended, but patients should be advised of the risk, signs and symptoms, and any suspected adverse reactions reported via the Yellow Card Scheme, he added.

For more information:

www.mhra.gov.uk

Warning against SSRI use in pregnancy

Babies exposed to SSRI antidepressants in the womb may be born with withdrawal syndrome, say researchers in *The Lancet*.

By screening the World Health Organization database of adverse drug reactions between 1968 and 2003, the investigators found 93 reports of SSRI use in pregnancy associated with either withdrawal syndrome or neonatal convulsions.

Of these, 64 cases were associated with paroxetine, 14 with fluoxetine, nine with sertraline and seven with citalopram. Treatment dose and duration was reported in only a minority of cases.

The authors conclude: "Paroxetine should not be used in pregnancy or, if used, should be given at the lowest effective dose. With the other SSRIs, especially citalopram and venlafaxine, their use should be carefully monitored and new cases promptly communicated to the pharmacovigilance systems."

Paroxetine should not be used in pregnancy, concluded researchers

In an accompanying editorial, Vladislav Ruchkin and Andrés Martin of Yale University School of Medicine's Child Study Centre say more work is needed to better understand how psychotropic drugs affect younger patients developmentally. But they warn against shifting away from widespread SSRI use, calling instead for "well defined clinical indications and a clear threshold to prescribe antidepressants".

For more information:

The Lancet 2005; 365: 482-487

Scriptlines

Optimax

Merck Pharmaceuticals has increased the availability of Optimax (L-tryptophan) 500mg tablets for depression.

Since 1994, Optimax has only been available as a named patient product because of a licensing requirement to monitor all patients for signs of eosinophilia myalgia syndrome (EMS). The manufacturer has now reached an agreement that the surveillance system is no longer necessary, so the product may be ordered via normal wholesale channels.

Treatment should only be initiated by hospital specialists in adults for whom trials of standard antidepressants have proved ineffective, or as an adjunct to other antidepressant medication.

The usual dose is two tablets three times a day, but up to 6g may be required for some patients. A lower dose may be appropriate for elderly patients, especially in renal or hepatic impairment.

Using Optimax in combination with a monoamine-oxidase inhibitor may enhance the MAOI side effects. In addition, care should be taken when using Optimax with a serotonin reuptake inhibitor as this may lead to 'serotonin syndrome', characterised by agitation, restlessness and gastrointestinal symptoms including diarrhoea.

Price: £19.56

Pack size: 84

Pip code: 213-5895

Merck Pharmaceuticals

Tel: 01895 452200

New Avandia indication

Avandia (rosiglitazone) is now licensed for use as part of triple therapy in combination with metformin and a sulphonylurea.

The product SPC states that Avandia may be used in this way in patients with diabetes, particularly those who are overweight with insufficient glycaemic control despite dual therapy.

Increased monitoring of the patient is recommended, as using Avandia in triple oral therapy may be associated with increased risks for fluid retention, heart failure and hypoglycaemia. In addition, switching the patient to insulin may be considered as an alternative to initiating triple oral therapy.

For more information:

GlaxoSmithKline UK Ltd

Tel: 020 8990 9000

www.emc.medicines.org.uk

Adipine XL

Trinity-Chiesi Pharmaceuticals has launched Adipine XL (nifedipine) tablets in 30mg and 60mg strengths.

The prolonged release tablets are indicated for the treatment of hypertension and prophylaxis of chronic stable angina pectoris, either as monotherapy or in combination with a beta-blocker. Adipine XL should be swallowed whole, once a day.

For more information:

See *Price List*

Trinity-Chiesi Pharmaceuticals

Tel: 0161 488 5555

Decapeptyl

Decapeptyl injection (triptorelin) is now licensed for the treatment of endometriosis.

The intramuscular injection should be administered every three months, with treatment initiated during the first five days of the menstrual cycle. Treatment duration depends on disease severity and observed changes, but should not exceed six months (two injections).

The SPC states that treatment may initially exacerbate endometriosis symptoms, but these should disappear in one or two weeks. Also, menorrhagia or spotting may occur in the month following the first injection.

For more information:

Ipsen Ltd

Tel: 01753 627627

Hypurin insulin

CP Pharmaceuticals has announced it will have resolved the supply difficulties with several products in its Hypurin insulin range by mid-March.

The company's anticipated availability dates are: Hypurin Porcine Neutral 3ml cartridges, February 20; Hypurin Bovine Lente 10ml vials and Hypurin Porcine Isophane 3ml cartridges, February 27; Hypurin Porcine 30/70 Mix 3ml cartridges, March 13. In addition, Hypurin Bovine Isophane 3ml cartridges are now fully available.

For more information:

CP Pharmaceuticals

Tel: 01978 661261

Seven Seas relaunch for flexibility

Seven Seas has relaunched its NeutraTaste Taste-free Cod Liver Oil brand with a new name and look.

The product will now be called NeutraTaste DailyFlexibility and the redesigned tubs are available this month.

Seven Seas' target market for the product is women who lead an active life and understand the need to maintain supple and flexible joints.

Product manager Ryan Ruscoe says: "The prominence of DailyFlexibility on pack strengthens the product's joint flexibility promise."

For more information:
Seven Seas Limited
Tel: 01482 375234

No time for pain, says Anadin poster appeal

Wyeth Consumer Healthcare is investing £70,000 in an outdoor poster campaign for its analgesic Anadin brand this February.

The campaign uses Anadin's yellow branding with the strapline: "Because mums don't take sickies" to highlight that people don't want pain to get in the way of their everyday lives.

The posters, which will appear outside major supermarkets and near pharmacies throughout the country, will run until the end of this month.

For more information:
Wyeth Consumer Healthcare
Tel: 01628 669011

Ad claims early pregnancy news

Church & Dwight is supporting its home pregnancy test brand, First Response, with a national television advertising campaign.

The adverts feature the First Response 'four-day claim' that its kit can detect a pregnancy four days before the missed period.

The "Find out first with First Response" adverts are already airing on terrestrial and satellite channels and will run until the end of the month.

For more information:
Church & Dwight
Tel: 01303 858 700

Medication made easy

Surgichem has launched a weekly disposable compliance aid to assist patients with medicines management.

It says the product is easy for both the pharmacist and patient to use, with clear labelling and tamper evident access to medication.

Surgichem will be promoting Nomad Clear at exhibitions and conferences this year.

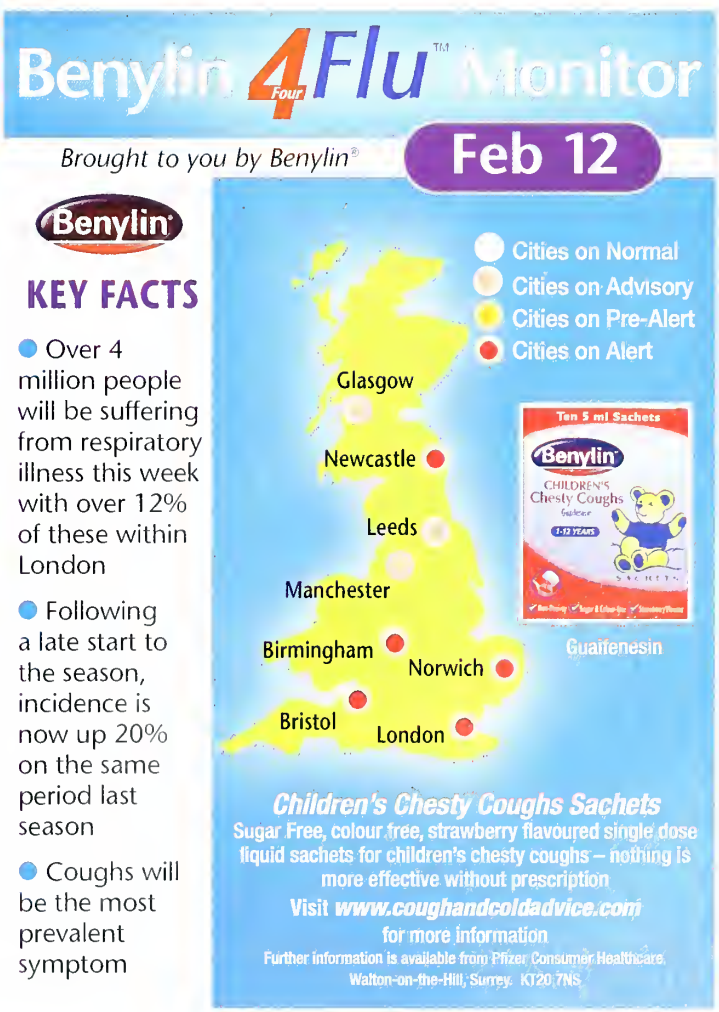
For more information:
Surgichem
Tel: 0161 406 8710

Pearl Drops shine again

Church & Dwight is supporting its Pearl Drops brand tooth whitening product with the relaunch of a previously successful broadcast advertising campaign.

The "Two shades whiter in three weeks" campaign, which Church & Dwight claim was responsible for a 112 per cent increase in sales in one month, will run until February 21.

For more information:
Church & Dwight
Tel: 01303 858700

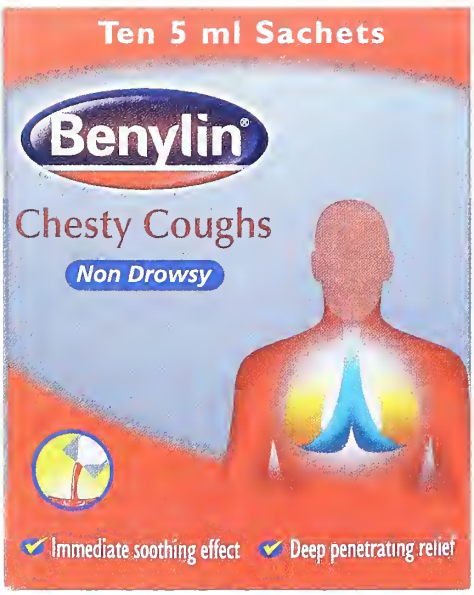


Benylin sachets for convenience

Benylin is launching Benylin Chesty Coughs in a sachet format.

The liquid will be in single dose 5ml sachets, boxed in packs of 10. Benylin Chesty Coughs Non-Drowsy Sachets and Benylin Children's Chesty Coughs Sachets are the only cough liquid available in this format. The children's variant comes in sugar and colour-free strawberry flavour syrup.

Consumer research showed that users are looking for liquid cough remedies in a portable format for daily use. The sachets have been funnelled to ensure minimal spillage.



Available from this month, the launch will be supported by the 'Coff, Coff, Off!' advertising campaign.

Price: 10x5ml sachets, £3.49 (adult), £3.29 (children).

Pip code: 310-2993 (adult)
310-3009 (children)
Pfizer Consumer Healthcare
Tel: 01304 616161

TV

Aquafresh: All areas except U, CTV, GMTV
Bisodol: Sat
Covonia: five, GMTV, Sat
Horlicks: All areas except U, CTV, GMTV
Kool 'n Soothe: All areas except C4, Sat
Kool 'n Soothe Migraine: All areas except C4, Sat
Lucozade Hydro: All areas except U, CTV, GMTV
Multibionta: C4, Sat
Nytol: All areas except U, CTV, GMTV
Olbas range: five, GMTV, Sat
Sensodyne: All areas except U, CTV, GMTV
Seven Seas Cod Liver Oil: All areas
Sudafed: All areas except U, GMTV
Voltarol Emugel P: B, G, Y, C, A, HTV, W, M, LWT, TT
Zovirax: C4, five, Sat
PharmaSite for next week: Nicotinell – window, **Fluconazole** in-store **Nicotinell** – dispensary
Pharmacy Channel: Beechams and **Night Nurse**

A-Anglia, B-Border, C-Central, C4-Channel 4, Five-Channel 5, CAR-Carlton, CTV-Channel Islands, G-Granada, GMTV-Breakfast Television, GTV-Grampian, HTV-Wales & West, LWT-London Weekend, M-Meridian, Sat-Satellite, STV-Scotland (central), TT-Tyne Tees, U-Ulster, W-Westcountry, Y-Yorkshire

Nurofen fires off new campaign

Crookes Healthcare is supporting its Nurofen Plus sub-brand with a national television advertising campaign.

The advert, which is aimed at 16-34 year old women, forms part of a multi-million campaign to support the Nurofen brand.

It is a 2-D animation featuring a Nurofen labelled telescopic cannon. The cannon fires two bursts of energy at a constantly pulsating spiky black cube, which disintegrates.

The campaign focuses on the brand message for Nurofen Plus:

"There's no stronger painkiller available without prescription."

The adverts will continue for three weeks.

For more information:
Crookes Healthcare Ltd
Tel: 0115 953 9922

Life's essentials for mums

Two separate nutritional supplements for pre- and post-birth women have been launched by mums essentials.

Taken daily, the capsules provide the appropriate levels of super concentrate essential fatty acids, including omega 3 (DHA) and omega 6 (GLA), which help the formulation of cells that make up the eye and brain in a developing baby.

The supplements come in packs of 30 (one month's supply) and cost £8.95.

Kevin Sweeney, managing director, said: "Historically, only a single supplement designed for both pregnant and breast-feeding women has been available on the market. As their nutritional requirements differ dramatically, we are delighted to be in a position to offer individual formulations tailored to meet their changing needs."

Price: £8.95

Pack size: 30 capsules
Pip code: Pre-birth 308-3540, Post-birth 308-3474
www.mumsessentials.com
Tel: 0800 0854 320

Travel wallet keeps the cold in

Sigma Pharmaceuticals has launched a cooler wallet designed to keep insulin and other medications at a safe temperature without being put in the refrigerator.

Frio Insulin Travel Wallets are activated by immersion in cold water for five to 15 minutes. Crystals contained in the panels of the wallet expand into a gel and relies on the process of evaporation to remain cool for several days.

The wallet, which can be towel dried after activation, can be carried in a pocket or hand luggage and is reusable.

For more information:
Sigma Pharmaceuticals
Tel: 0800 358 6601

THE BEST SELLING* MEDICINE FOR COUGHS AND CARS, HANDBAG[S] TRAIN JOURNEYS, A[T] THE CINEM[A] WORK, WALK [IN] THE PARK...

*IRI 02 Oct 04.

Now your customers can have fast, effective Benylin relief to hand whenever they need it, wherever they are. Benylin Chesty Coughs Non Drowsy now comes in the ultimate portable form – unique single-dose liquid sachets, available for adults and children. It's a product with year-round appeal, so be sure you can meet the demand. **Nothing is more effective without prescription.**

ylin Chesty Coughs (Non-Drowsy) Product Information. Presentation. Syrup containing [illegible] years: 10 ml four times daily; children aged 6-12 years: 5 ml four times daily; ch dren under [illegible] curs with asthma, or where cough is accompanied by excessive secretions; caution in [illegible] 5ml sachets £3.49. Legal category: GSL. PL Holder: Pfizer Consumer Healthcare, [illegible]. mation: Presentation. Solution containing 50 mg Guaifenesin per 5 ml. Uses. The symptomatic [illegible] hildren under 1 year. Contraindications: Known hypersensitivity. Precautions. Do not use for persistent cough e.g. asthma, [illegible] rare. RRP (ex-VAT): 125 ml bottle £3.29, 10x5ml sachets £3.29. Legal category: GSL. PL holder: Pfizer Consumer Healthcare, [illegible]. [illegible]

New horizons

The business sessions of the Numark Conference held in Mauritius last week looked at the new pharmacy contract, POM to P switches and CPD as well as a round-up of Numark activity. Charles Gladwin reports

The pharmacy contract is central to the Government's strategy for improving health and primary care services, said Jim Smith, chief pharmaceutical officer for England.

"The new contract was not dreamed up in isolation; it flows directly from and is deeply rooted in a whole raft of initiatives from the Department," he said.

With the existing contract 20 years old (although Professor Ian Jones was later to argue that it had not changed significantly since 1911), Dr Smith said the aim was to make the new contract more flexible. "A lot of people think the new contract is not inspiring," he said, but added: "You could argue that it is volume driven, but there is huge scope in the contract to move away from volume."

He also said that there were many enablers around the new contract, including IT, skill mix, public health and reclassification of medicines. And with over 330 pharmacists registered as supplementary prescribers, the DoH is in the final stages of drafting a paper on independent prescribing to submit to ministers in the next few weeks. Legislation could then be proposed by the end of the year.

He stressed that there is "massive commitment" to making electronic transfer of prescriptions work and to give electronic connectivity to pharmacy, although he acknowledged: "It won't be easy. We are tackling the issue of access to the national care record. The consultation has been delayed and we are redrafting the paper, but there are massive issues around sharing patient information, confidentiality and patient consent." However, he said that pharmacy was in the vanguard and that once it went ahead, pharmacists would be the first community-based practitioners after GPs to be linked in.

In terms of skill mix issues, Dr Smith said the current law was not fit for purpose and has been a constraint on development. What has now been proposed in terms of pharmacist supervision would not be mandatory, but should be seen as an enabler. "We are suggesting, in short, that the pharmacist need not always be present to exercise control," he said. "We will retain supervision, personal control (which we will redefine – the mess we are in now is because personal control has never been defined) and with corporate pharmacy we will still need a pharmacy superintendent."

Resolution should be the new watchword

Pharmacists should now be starting to take advantage of the opportunities being presented in the new contracts, suggested Musa Dhalla of Webstar Health. "I would suggest we need a new watchword: resolution. You should resolve to implement the new contract."

Mr Dhalla pointed out that the new contract is to be "fairly funded. But I have not seen any information or data to say what is 'fair'," he said. This means it is a matter of pharmacy contractors having trust in PSNC, although without knowing what the 'fair funding' terms are, he could not say whether the return on capital in pharmacy is comparable to other areas of business and industry.

While the new contract is still volume based, he said it was difficult to come up with new payment mechanisms which do not take into account this core service. However, although many of the essential services are currently related to prescription volume, he said this will change as the financial flows change. "There will be evolution where we might have wanted revolution."

From April 1, the *Drug Tariff* will be adjusted to take out £300 million so as changes are made to the way generics are reimbursed, the focus will change from chasing discounts to finding new ways of working for sources of income. Within the new contract medicines use reviews will be the first service within the advanced service tier.

However, research carried out by Webstar Health and Keele University showed a contrast in PCTs' expectations about MURs and what they would prefer. While 31 per cent thought that

The view from the Domaine du Chasseur

Keep an eye on generics prices for time being

Despite changes being brought in to standardise reimbursement for generic medicines, pharmacists should still look for the best prices.

This was the view of John Beighton, immediate past chairman of the British Generics Manufacturers' Association and managing director of generics company Teva UK.

From April 1 the new *Drug Tariff* will be structured to cut £300 million from the UK drugs budget. The listed reimbursement prices will be based on all the market suppliers' figures and not just a representative 'shopping basket' of certain companies.

"Because reimbursement will have a much more direct relationship to market prices, we will see a much more real relationship between the market price and the reimbursement price." Any price changes made by manufacturers will be picked up by the *Drug Tariff*, and will include every method of discounting, he said.

"Many of you will be starting to think less attention will need to be spent on generics, but I would still say it is in the best interests of pharmacists to buy as competitively as possible." He was certain that vertically integrated pharmacy chains would not be slackening up on their pricing efforts.

Mr Beighton expects that more and more pharmacists will start aligning themselves with a major generics manufacturer, not only for consistency of supply, but also to maximise on competitive deals.

Mr Beighton challenged the Government to be more vocal in tackling branded pharmaceutical manufacturers' attempts to limit generic competition.

He explained that European policy on medicines supports 'headroom'; generics competition is favoured as it lowers prices of medicines by introducing competition with branded manufacturers, while at the same time encouraging new product development.

However, Mr Beighton said: "We do know that despite some commitment to headroom, the principles are not always being followed. We do get support from the DoH, but we would like to see that support much more vociferous than it is."

pharmacists would be left to select patients for MURs, only 8 per cent of PCTs would prefer pharmacists to do the selection. Only a quarter (25.8 per cent) thought that MURs would operate through patients being targeted under guidelines, although nearly half (47 per cent) would prefer targeting. About 44 per cent of PCTs thought and hoped there would be local discussions about the implementation of MURs.

More worrying, only 5.2 per cent of PCTs thought that pharmacy premises were ready, and only a fifth had confidence that pharmacy could deliver. "Whether this is real or their perception, it's their belief and we have to address that, through lobbying, demonstrating experience and through delivery," he said. And while almost 60 per cent of PCTs report a good relationship with their LPC, that means 40 per cent do not.

Local lobbying is worthwhile

Pharmacists should continue to lobby their local MP about pharmacy issues, urged Lord Fowler, Numark chairman and former health secretary in Mrs Thatcher's cabinet.

MPs are influenced by their constituents. "The broad rule is that MPs today regard their constituency as all important," he said. MPs may be guarding a small majority, but much more than that, all MPs are community politicians – they listen to what they are told and act upon it.

"The first and most effective way of getting a case over is at the constituency level. Pharmacy, and independent pharmacy in particular, is very well placed. MPs see [pharmacists] as very well placed in the community, so will listen to pharmacists. The campaign on the OFT decision is a very good example of what can be achieved."

The supermarkets are big enough to look after themselves, he said, but independent pharmacies must play to their strengths. "The supermarkets have access to the ministers in the DTI if not the DoH. But your strength is at the community level.

"It's crucial that you keep you local links with your local representatives. MPs do not want to have a reputation of not listening. They support the idea of independent pharmacies; they are not natural supporters of the big supermarkets."

Pictured on the lawns of the Sugar Beach Resort are, from the left: Nola Ward, Numark chairman Lord Fowler, Lady Fowler and William Ward

MURs by every pharmacist

Medicines use review is not about selecting people with the most complex clinical needs. It is more the kind of simple review that everyone with a chronic condition should have once a year. "It is, in essence, what being a pharmacist is all about," said Alison Blenkinsopp, professor of the practice of pharmacy, Keele University.

It is a practical review of patients' medicines under advanced services in the new contract; it isn't full clinical medicine review which is an enhanced service, she said. The level of clinical input in MURs will be at *British National Formulary* level.

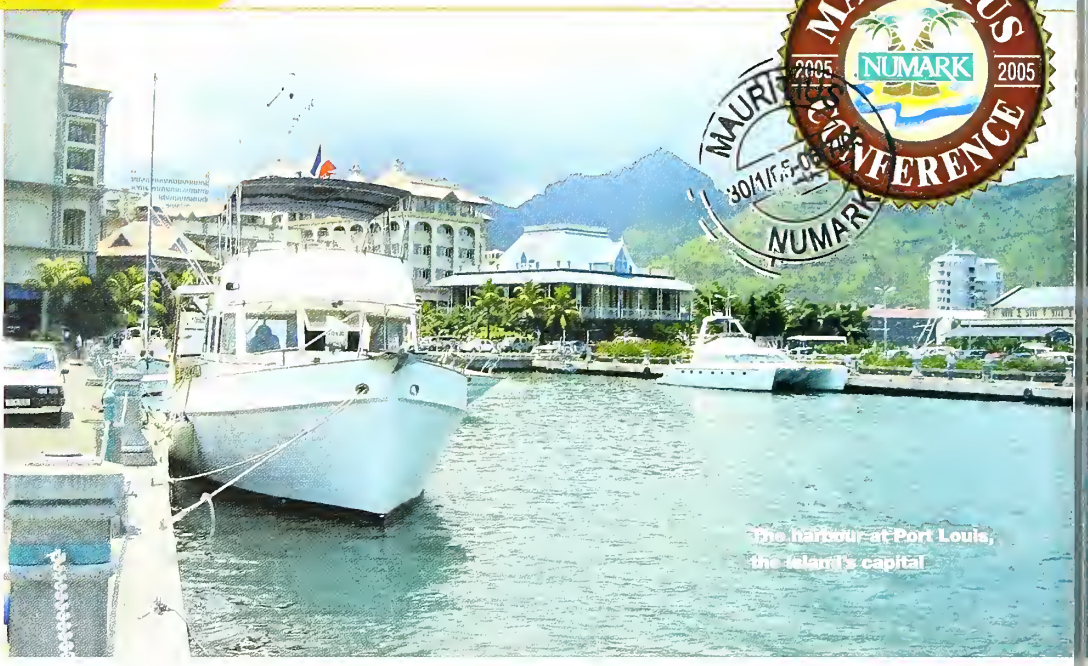
The new contract will allow every pharmacy, once accredited, to be paid for up to 200 MURs in the first year, equivalent to two million in total, and the indications are that more money will be made available in future to extend the service if it is successful.

However, this success will depend on a variety of factors, including awareness of the

Some patients may not understand why they should suddenly receive a medicines review

scheme by GPs and the approach to patients who may not understand why their medicines are being discussed. "Some patients may not understand why they should suddenly receive a medicines review. MURs will be new to many patients – they need to know what it's about," said Professor Blenkinsopp, who added that the Primary Care Pharmacists' Association is preparing a leaflet explaining MURs to patients.

While the scheme is likely to expand in England, Professor Blenkinsopp pointed out that the model in the proposed new Scotland contract is to move towards a chronic disease management service.



The harbour at Port Louis, the island's capital

Look to potential POM switches for CPD

Pharmacists should not wait until a product is available over the counter to learn more about the OTC use. They should look instead at which Prescription Only Medicines have been mooted for switch potential, as well as any consultations that are taking place, to initiate training for themselves and their staff.

"You must understand the products that are going to change. And not only must you know about them, but you must also educate you staff about them," said Dr John Blenkinsopp, senior research fellow at Keele University and a consultant on POM to P switches.

He believes that medicines should be available as widely as possible but as safely as possible.

Three notable lists of potential and/or desirable POM to P switches have been drawn up in recent years – by the NPA, the RPSGB and the Department of Health (which has doubled the target of switches to 10 per year).

These lists should act as a guide to CPD for pharmacists, he proposed, although he called on the Society to reappraise its long list as it contains recommendations for products where safety profiles may have changed, such as Cox- 2 inhibitors.

Though his work in advising companies on POM to P switches means he cannot name specific products, Dr Blenkinsopp's suggested list of areas to get ready for the new POM to P switches include:

- hypertension
- asthma
- migraine
- acne
- cystitis
- analgesia
- erectile dysfunction.

He also challenged the medical profession, suggesting GPs might be more in favour of switches than their representatives would argue. Research carried out last year by Keele University found that 94 per cent of GPs were in favour of topical antibiotics being made available OTC and 61 per cent were in favour of OTC tryptans for migraine. However, GPs are still unsure about thiazide diuretics for blood pressure.

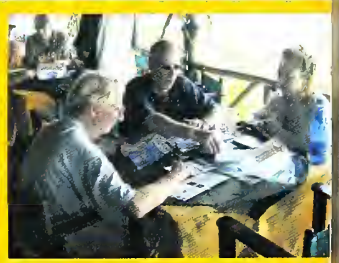
Pharmacists still unsure about CPD approach

Pharmacists still lack confidence in their approach to continuing professional development. While about one third of pharmacists have actually started using the online CPD recording system on the Royal Pharmaceutical Society's website, a third have visited the site without making any records but the remainder so far have done nothing about recording CPD.

Alison Blenkinsopp, professor in the practice of pharmacy at Keele University, said that the two big barriers at the moment are pharmacists not being sure about what constitutes CPD and what to record and concerns that recording CPD will take up too much time.

CPD is about asking how a piece of learning has affected the way a pharmacist practices, she said. "Your CPD record is about how this will help you with your practice ... it's about the public having confidence in that you are up to date."

For those pharmacists who are reluctant to go online, the RPSGB is issuing a desktop version of the recording system on CD-Rom this week. In addition the Society is putting up 20 examples of CPD records on the website to give other pharmacists an idea of the sort of material that is required.



Numark members were given the chance to meet suppliers in the mountain top reserve of the Domaine du Chasseur

'Be more assertive over selling simvastatin'

Pharmacists are reluctant to sell simvastatin, even when the customer fills all the eligibility requirements of the product licence for the OTC cholesterol lowering drug.

Mystery shopper research, using only people who were suitable for OTC simvastatin, found that only 32 per cent of cases resulted in the patients being sold the drug; in the independent pharmacy sector the figure was 23 per cent.

And despite fulfilling all the protocol requirements for suitability, 51 per cent of pharmacists (and 6 per cent of medicines counter assistants) were referring the customer to the GP. "Why refer these people to the GP? There was no need to do it," said Chris Markwick, customer development manager, of McNeil, the manufacturer of Zocor Heart-Pro.

These referrals were missed opportunities, he said. "GPs are not going to prescribe for these people with a moderate risk over the next 10 years. They are your customers that you can help."

Research suggests that pharmacists perceive the time element in assessing the patient as a problem. However, Mr Markwick argued that the 8-10 minute interview is an exceptional way to build customer relations and customer loyalty.

He also pointed out that going through the questionnaire with the patient doubles the likelihood of a sale, as not only is the pharmacist more confident about the suitability for the patient, but the patient is able to find out more about the drug. And nor is a cholesterol test a requirement of the product licence.

But a fifth of patients are still not confident about the questionnaire, and only 3 per cent of pharmacists are actually initiating conversations about cholesterol lowering therapy.

"There's a vast number of people who want to know about and want to discuss it," he said. "You need to be skilled in entering customers into a dialogue."

Numark TV success

The publicity campaign for the Numark brand has increased public awareness by nearly a fifth.

Following the television adverts last autumn, awareness was up 10 per cent to 64 per cent, while public awareness of other pharmacy brands was relatively unchanged, said Andrew Sollitt, marketing director at Numark.

The aim of the ongoing campaign has been to differentiate the Numark service from other local and national providers. It strengthens the various elements of Numark branding from shop facias through to Numark brand products, and has also added to the 'best prices' perception, said Mr Sollitt.

Numark hopes to widen its customer appeal which currently centres on the over-55s and young, less advantaged mums. "We need to expand the customer base if we are to grow the brand in the future," he explained.

The effects of the television campaign are demonstrated by the sales of four medicines featured in the campaign. (Numark Ibuprofen sales were up 79 per cent, Numark Paracetamol Syrup 76 per cent, Zanprol 99 per cent, and Anusol 30 per cent.)

Website hits almost doubled in three months from about 93,000 a month to 176,000 in December. Numark now has the same Google internet search rating as Boots and is ahead of Vantage and Lloydspharmacy, said Mr Sollitt.

The television campaign will run again from May to July, this time highlighting allergy relief, anti-diarrhoeals, cold sores and paediatric relief. It will also be building on its local PR activity with a toolkit for members to create local news stories through templates, press releases and briefing notes.

Numark currently has 1,714 members who are benefiting from over £14 million per year in rebates, Numark chief executive David Wood told delegates. This is based on turnover approaching £55m. Profit before tax is estimated at £1.5m, a tenfold rise in five years.

The numbers game

Are the suncare companies doing enough to provide accurate information in the best interests of the consumer? Sarah Thackray reports

Consumer confidence in sunscreens was shaken last summer by a highly publicised *Which?* report that raised concerns about whether some brands live up to their claims.

The *Which?* report suggested that sunscreen users could be at risk because the SPF numbers declared on some sun products may not offer the full protection they claim.

Two own-brand products failed to meet the industry standard for SPF15 when tested by *Which?* Boots Soltan and Superdrug Solait SPF15 were found to have SPFs of 10 and 11 respectively.

SPF variability

Sunscreens are allowed to be 20 per cent either side of the claimed SPF since, even when the same test method is used, test results can vary due to human variation and the difficulty of measuring skin redness. This variability was highlighted in the *Which?* test by other SPF15 or 16 sun products which were found to offer a higher SPF rating than the one claimed.

Ambre Solaire was found to have SPF18, Nivea Sun was SPF18 and Piz Buin was SPF19. *Which?* concluded that the current test methods are not good enough and suggested that the suncare industry needs to work towards a more robust test to reduce variability.

Dr Chris Flower, director-general of the UK's Cosmetic, Toiletry & Perfumery Association (CTPA), says European sunscreen manufacturers follow an international standardised testing guideline for measuring SPF which is robust and has taken many years to develop. He comments: "The test is technically demanding and attention to every detail is required to ensure reproducible, and therefore reliable, results. The necessary checks and controls are part of the test to ensure it is valid."

Dr Flower points out that because the testing involves people and people differ, a residual degree of biological variability within the result is inevitable. "Statistical methods check the technical validity of the test and take biological variability into account to ensure that the product on the shelf will deliver the protection indicated on the label, but this is the average SPF from a cross-section of the population in the test," he says.

The *Which?* report suggested that the SPF on the label should reflect the lower end of the range to ensure products don't fall below the protection level on the label. So, a product with an SPF of 15, for example, would need to be within a range of 15 to 20, rather than the 12 to 18 that is currently acceptable.

However, Dr Flower believes this would be misleading and could give consumers a false sense of security. He explains: "Saying that a product will provide a minimum SPF rather than a mean SPF is actually more difficult statistically as you can always find another person even more sensitive."

European suncare manufacturers are recommended to use the mean SPF as a basis for labelling. The mean value from the test is rounded down to the nearest whole number in the SPF classification table shown and this number is the maximum SPF to be labelled. Manufacturers should not round up SPF test results to the nearest number in the SPF classification table (*see box on p33*).

The maximum SPF labelled should be SPF 50+. For a product to be labelled as SPF 50+, the mean SPF measured must have been

What are people buying?

As the safe tan message hits home, more people are heeding warnings about the risk of sunbathing and are buying more self-tanning products and higher factor sunscreens.

As self-tanning has become more popular, major brands have expanded in this sector, helping to drive growth.

Self-tanning products are the undoubted stars of the sun preparation market and saw a 17 per cent sales increase last year. This sector now accounts for 21 per cent of the total market, according to Information Resources.

Sun protection products showed a 4 per cent increase last year and now represent 67 per cent of the market. After-suns make up the remaining 12 per cent of the market.

Retailers are finding an increased demand for higher SPF sunscreens and are increasing facings accordingly. Sun products with an SPF between 20 and 29 grew by 14.5 per cent in 2004. The children's sun protection sector grew by 35 per cent in 2004.

According to a recent Mintel report, higher SPF sunscreens of over 30 have grown at more than twice the sector average since 2001 and sunscreens with SPFs of 21 or more now account for over 40 per cent of sales. SPF15 remains the single best-selling sunscreen.

Picture: Malibu

Mintel says that lotions and milks remain at the core of the sun protection sector, claiming 60 per cent of value sales. However, lotions have lost share to sprays which have captured around a fifth of sun protection sales.

Creams account for around 8 per cent of the sun protection sector.

Consumer research shows that women aged 25-54 are the core buyers of suncare products and that men are far less inclined than women to use the products.

Volume purchasing is greatest amongst people with children.

Top suncare brands

1. **Ambre Solaire**
2. **Malibu**
3. **P20**
4. **Nivea**
5. **Solar Expertise**

Source: Information Resources volume sales in independent pharmacies, year ending October 2, 2004

"Self-tanning products are the undoubted stars"

SPF classification table

Type	SPF
Low	2-4-6
Medium	8-10-12
High	15-20-25
Very high	30-40-50
Ultra	50+

Source: The European Cosmetic Toiletry and Perfumery Association

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SPF60 or above and the term sunblock should no longer be used. All labelling of European suncare products should comply with these guidelines by the end of 2005.

Star ratings

Which? also found that some of the products it tested fell short of their UVA claims. The report said its tests showed that Nivea's children's sun spray "offered significantly less protection than its three-star rating promised."

Only the Boots Soltan sunscreens tested lived up to their claim of maximum five-star protection according to *Which?*

The star rating system is generally used for UVA labelling on sunscreens marketed in the UK but is not universally accepted internationally. The star rating is relative to the SPF figure so that more UVA protection is required in absolute terms to get a three-star rating on an SPF25 product than is necessary for a three-star rating on an SPF10 product.

However, there is criticism that the star system does not successfully measure the ability of a sunscreen to protect against UVA.

Richard Anderson, MD of Sunsense distributor JJS Pharma, points out that a sunscreen with an SPF of 60 and a UVA star rating of two may actually provide the same (or more) UVA protection than a sunscreen with an SPF of 30 and four UVA stars.

According to the Australian manufacturer of Sunsense, the reason for this is that the UVA stars actually refer to the ratio of UVA absorbance to UVB absorbance. So if the SPF is very high, eg 60, the UVB absorbance will also be very high. The company says that if the UVA absorbance is the same as that of the SPF30 sunscreen it follows that the ratio of UVA to UVB will be lower in the sunscreen with the higher SPF.

In Australia, the regulated method for rating UVA involves an approved *in vitro* test. Using this method, the sunscreen is shown to allow no more than 10 per cent transmission between 320nm and 360nm. If a sunscreen passes this *in vitro* test and has a label claiming SPF of no less than four, it can be called broad spectrum.

Mr Anderson of JJS Pharma points out that the Australian method does not penalise a high SPF sunscreen. He says: "The consumer is less confused by the Australian system. To find a good sunscreen, you find one that is 'broad spectrum' and then you pick the SPF you want. The consumer does not have to try and understand a twin rating system, or be confused by a numbers game."

The problem of accurate UVA measurement is one that European suncare companies are currently addressing and there is confidence that a new system will be agreed this year.

Dr Flower of the CTPA says: "The sunscreen manufacturers are working hard to develop a new European standard for UVA measurement and labelling that will be both accurate and widely accepted."

Philippa Varney, Malibu marketing manager, comments: "Consumers should be provided with easily understood and reliable information to help them with their purchasing decision. Clearly, it would make sense if there was commonality of testing and labelling across all brands."

Continued on page 34

What's new

Australian suncare brand Sunsense is being relaunched into UK pharmacies by a new distributor - JJS Pharma.

Newly established JJS Pharma specialises in marketing and distributing premier ethical and consumer skincare products.

"All the Sunsense products have been formulated and produced to standards set by the Australian Therapeutic Goods Administration which regulates sunscreens as pharmaceuticals," managing director Richard Anderson points out. All sunscreens in the range have an SPF of at least 20 rising to SPF60 for Daily Face which combines a moisturiser with sunscreen.

The seven product line-up (which includes two toddler products) retails from £5.49 for Ultra Roll-on to £9.99 for Daily Face and Low Irritant.

The relaunch will be supported by consumer education, sampling activity, promotions and an advertising campaign during the peak summer season.

Trade promotion deals, in-store merchandising and customer incentives will be available to pharmacies.

JJS Pharma Ltd, tel: 01477 537 596

A dual-action self-tanning cream will be launched into L'Oreal's Sublime Bronze range in mid-March.

Sublime Bronze Instant Tan (£10.99, 30ml) is formulated to provide instant bronzing make-up plus a lasting golden, natural-looking colour. The cream includes natural colour pigments similar to those found in tinted moisturisers to give the skin an instant glow without having to wait for the colour to develop.

The formulation contains AHAs to exfoliate and smooth the skin, prevent tell-tale orange streaks and ensure an even result. The tanning lotion develops gently over time, leaving a subtly golden colour.

L'Oreal Group UK, tel: 020 8762 4000

Bydis Healthcare is introducing the Kolastyma Laboratorium range of suncare products into UK pharmacies.

Manufactured in Poland, the comprehensive range includes 29 products offering all levels of protection from SPF5 to SPF35. The line-up includes three lotions for sensitive and allergy-prone skin, four waterproof lotions for kids and three self-tan products. It also features after-sun products, a suntan enhancer and a suntan activator.

Retail prices range from £3.51 for waterproof suntan lotion SPF5 to £6.13 for suntan lotion for sensitive and allergy-prone skin SPF30.

A free eye-catching display stand is available for pharmacies. Promotional giveaways include beach balls and towels, T-shirts, beach bags and an inflatable seal for children.

Bydis Healthcare Ltd, tel: 0870 240 7842

A chemical-free suncream that is suitable for people with very sensitive skin or skin conditions such as eczema or psoriasis is new from Ultrasun.

Reflex30 (£15.95) provides UVB30 and high UVA protection filtering 99 per cent of UVA rays. It is formulated with vitamin B5 to moisturise and soothe the skin and contains extra water resistance.

Unlike other Ultrasun suncreams, it has to be reapplied and is not a once-a-day product. It contains no preservatives but comes in an airless dispenser with a special seal giving it a shelf life of up to three years.

The cream does not contain fragrance, alcohol or mineral oil. It is dermatologically and toxicologically tested.

Staff training, samples, consumer leaflets, promotional visits, posters and display material are available for pharmacies.

Ultrasun (UK) Ltd, tel: 01737 245499

New in the Malibu range this year is a smaller 200ml size of After Sun with Insect Repellent (£2.99). The product replaces the previous 400ml size.

The cooling, non-greasy lotion contains an insect repellent which is claimed to be effective for fours hours against biting and stinging insects.

Malibu Health Products Int Ltd, tel: 020 8758 0055

in suncare?

The entire Delph sun protection range for 2005 offers a higher level of UVA protection than before. Fenton Pharmaceuticals has reformulated its value for money range with four-star UVA protection.

Products range from SPF8 up to SPF50 and the medium to high SPFs contain infra-red filters to help stop the skin overheating, which can intensify UVB effects.

The products are enriched with vitamin E to help protect against skin ageing and peeling.

Fenton Pharmaceuticals Ltd, tel: 020 7224 1388

Medium to high protection in a clear sun protection spray is a new development from Garnier. Available from March, Ambre Solaire Clear Protect is a light transparent spray formulated to provide a quickly absorbed product that is both non-greasy and non-sticky. The sprays will come in three levels of protection – SPF10, SPF20 and SPF30, retailing for £11.49, £13.49 and £13.99 respectively.

Julie McManus, Garnier's scientific advisor, comments: "Although transparent formulae have been around for a while, the problem was that it was difficult to achieve an even distribution of sun filters on the skin." She says that this meant that clear products could previously only be made in low SPFs.

"Clear Protect sprays contain a special polymer which allows even distribution of UV filters onto the skin," she explains. The polymer is combined with Garnier's filtration system Mexoryl XL.

Garnier, tel: 020 8762 4010

The Uvistat sun range is now owned by LPC Medical (UK) following the company's acquisition of Eastern Pharmaceutical's licences at the end of last year.

The Uvistat brand was developed by Boehringer Ingelheim Self Medication to provide suncare protection to a pharmaceutical standard. The range features a wide selection of high-factor sunblocks, lotions, sprays, sticks and lipscreens. All the products carry four-star UVA ratings and claim to block out UVA and UVB in equal amounts. The range will be promoted via the wholesaler

LPC (Pharmaceuticals) Ltd, tel: 01582 560393

Lifes2good has renamed its Body Bloc which is now part of the Nourella range.

Now called Nourella Sunsense 20 (£12.95), the SPF20 product with aloe vera has the same non-greasy, waterproof formula as before.

Scalp Bloc has also been repackaged and is now called Nourkrin Scalp Bloc (£12.95).

Featuring a nozzle applicator, the SPF20 product is formulated to protect the scalp and face and is suitable for people with fine, thinning and close cut hair.

Both products are designed to be applied once a day and have a three star UVA rating.

Life2good, tel: 08453 990022

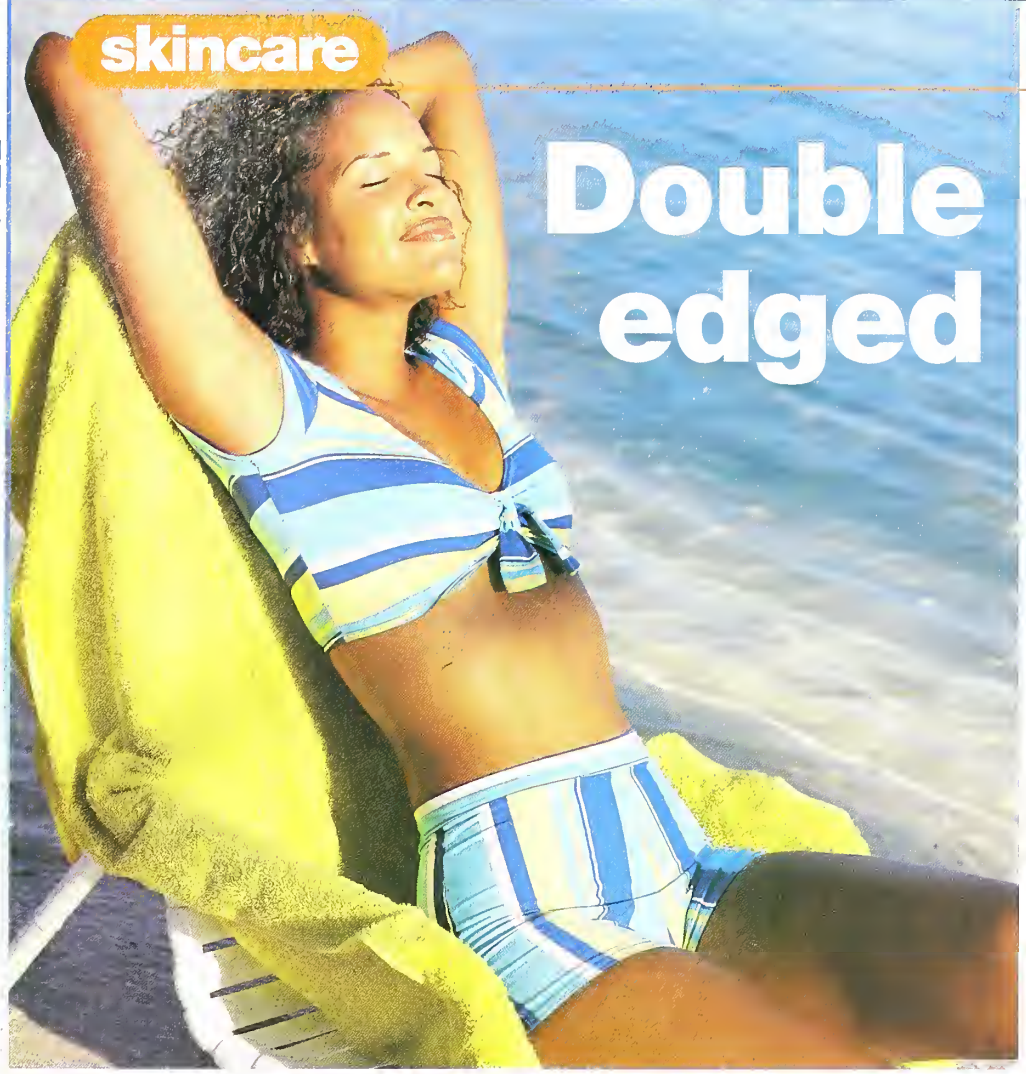
Weleda's Edelweiss suncare range is currently being promoted with a discount of 10 per cent on each of the three products in the range.

The chemical-free range is formulated with mineral UVA and UVB filters made from naturally occurring titanium dioxide and zinc oxide. The products also contain edelweiss extract to alleviate irritation and help prevent premature ageing or wrinkling.

A trade parcel (£69.58) includes six of each products plus a poster conveying the natural ingredients message.

Weleda Pharmacy Retail, tel: 0845 2002836

Continued on page 36 ▶



Double edged sword

We all know that the sun can damage our skin, but the flip side is that it can do our spirits a world of good and can help alleviate some skin conditions. Pharmacist Rod Tucker reviews the evidence

There is increasing evidence linking excessive exposure to the sun and the risk of skin cancers. It is thought that nine in 10 non-melanoma skin cancers and six in 10 melanomas are caused by excessive sun exposure. In addition, more than 2 per cent of the estimated 50,000 cases of skin cancer each year in the UK prove to be fatal.

Skin cancers

There are two types of skin cancer - the non-melanomas and the melanomas, with the latter being the more serious.

In recent years, evidence suggests that the incidence of all forms of skin cancer is steadily on the increase. There is now good evidence that the development of non-melanoma skin cancers are related to exposure to the sun.

The two most common non-melanoma cancers are basal cell carcinomas (BCC) and squamous cell carcinoma (SCC):

- Basal cell carcinomas, which are the most common form of cancer in Caucasians, arise in the basal skin cells of the epidermis and occur mainly on the hands and arms.
- Squamous cell carcinomas occur in the uppermost epidermis and appear as a thickened and scaly area of skin. They are often found on sun exposed areas such as the hands, face or scalp and are commonly found on women's legs.

The association between the more serious melanomas and sun exposure is less clear, though evidence suggests that intermittent sun exposure and sunburn during childhood are important factors in their development in later life.

Positive effects of sunlight

While overexposure to the sun is clearly harmful, sunlight can exert a positive effect on our mood, probably due to the increased release of endorphins. In addition, the development of a suntan often makes people feel better about themselves. Furthermore, there is increasing evidence that sunlight reduces the risk of certain cancers such as those affecting the breast and prostate gland. The sun also acts on the skin to produce vitamin D which is important for optimal functioning of bones.

Skin conditions

Many patients with common skin conditions such as acne, eczema and psoriasis can gain benefit from sunlight:

Acne

Many acne sufferers find that during the summer months their skin improves. However, in climates that have a high degree of humidity, acne can often worsen, due to increased sweating which further blocks the pilosebaceous follicles.

Recent research has begun to elucidate the possible mechanisms through which sunlight improves acne. Using light at specific wavelengths, namely 440 and 660nm (which are part of the visible spectrum) appears to improve the severity of acne.

The reasons for this, while not fully understood, probably involve the production of porphyrins inside the *Propionibacterium acnes* bacterium (the so-called 'acne bug' present in pilosebaceous follicles). These porphyrins, once excited by the light, produce oxygen which kills the *P acnes*, leading to an improvement in acne.

Moreover, since the light is part of the visible spectrum, there is little chance of developing skin cancer or premature ageing. Lamps delivering the specific wavelengths are commercially available and pharmacists who require further information should contact the Acne Support Group, tel: 0870 870 2263.

There is increasing evidence that sunlight reduces the risk of certain cancers

Eczema

The sun tends to produce improvements in atopic eczema for most patients. Some patients with seborrhoeic eczema find that sunlight initially worsens their condition, which often then improves after a few days.

However, patients with photosensitive eczema, which fortunately is rare, always find that their eczema worsens in the sun. There is now evidence from clinical trials that narrow band (311± 2nm) UVB radiation (which is often used to treat psoriasis) is effective at improving atopic eczema. The way in which sunlight improves eczema is unclear, though there is some evidence that UVB light can induce anti-

nflammatory and immunosuppressive ytokines.

Psoriasis

It is a well-established fact among sufferers hat psoriasis improves after a few weeks' exposure to the sun. In fact, the natural pproach to treating psoriasis has been termed 'climatotherapy', involving holidays in Florida, he Mediterranean, Caribbean or Dead Sea.

Furthermore, many hospital-based reatments for psoriasis such as Psoralen-Ultra Violet A (PUVA) or narrow band UVB treatment, involve the use of specially designed UV light chambers.

Many psoriasis sufferers report a positive outcome from the use of commercial sunbeds and though generally not recommended by dermatologists, one study has shown a reduction in the severity of psoriasis after the use of such tanning beds.

Role of the pharmacist

Community pharmacists are ideally placed to offer advice to patients with skin diseases who require information about using their treatments during the summer months. In general, it is sensible to advise all patients how to avoid burning in the sun (*see box, left*).

For acne sufferers it is important to avoid oily sunscreens, which can exacerbate their condition. The ideal choice would be an oil-free sunscreen or one labelled 'non-comedogenic'.

Pharmacists should also advise patients prescribed topical retinoids such as adapalene (Differin) as well as benzoyl peroxide, to use a suitable sunscreen since these drugs increase the skins' sensitivity to the effects of sunlight.

In addition, certain antibiotics used to treat acne such as oxycycline can cause photosensitive reactions and again, patients should use a sunscreen.

Patients with eczema, who already have sensitive skin, should be encouraged to experiment with sunscreens prior to purchasing them. This can be achieved by applying a small amount of the sunscreen to the inside of a patient's arm and waiting 24 hours. If the skin becomes itchy or inflamed, then the patient is clearly sensitive to one or more of the ingredients present and should not use that product.

As sunscreens can be expensive, it is worth advising patients about own-brand preparations which can be equally effective. Furthermore, it might also be worth letting patients know which sunscreens are available on prescription.

As sunlight has a drying effect on skin, eczema sufferers should be advised to use more of their usual emollients. Ideally, patients should apply their emollients about 30 minutes before applying a sunscreen to avoid diluting the effectiveness of the sunscreen.

Finally, for eczema sufferers going on a beach holiday, they should be warned that sand, salt water and even the chlorine in swimming pools can be irritating. Liberal application of an emollient prior to swimming and a tepid bath or shower after a visit to the beach or pool (as well as the usual post shower/bath application of emollients) should help soothe the skin.

Similar considerations apply to psoriasis sufferers, though patients should be warned that sunburn can make psoriasis worse. Again, it seems sensible that patients apply their treatments some time prior to the use of a sunscreen.

Alternatively, they could limit the application of their topical treatments to once a day, perhaps at night. As with acne therapies, some patients might be prescribed retinoids for psoriasis and should therefore use a sunscreen.

Finally, pharmacists should be alert to the fact that many drugs can cause photosensitive reactions and if patients present with an erythematous reaction after being in the sun, it is important to consider possible drug causes (*see the BNF for details*). Clearly such patients should be advised to use sunscreens.

Protecting skin from damage

Excessive exposure to the sun can be reduced by observing the following simple steps:

- Remember that a suntan is not healthy but rather a sign of skin damage and the body's response to the effect of UV rays.
- Avoid the sun between the hours of 11am and 3pm when the sun is highest in the sky and hence at its most powerful. The sun is also more powerful at higher altitudes – so skiers and mountain climbers need more sun protection. It is also important to remember that the sun can be reflected off surfaces such as snow, water and concrete.
- Always use a sunscreen to reduce the potential for skin damage. The sun protection factor (SPF) describes how much longer you can stay in the sun compared to having no protection. For instance, if you burn after 10 minutes in the sun, an SPF of 15 means you can stay in the sun for up to 150 minutes before burning. It is important to use a sunscreen with an SPF of at least 15.
- Many people fail to apply sufficient sunscreen and 100ml is estimated to cover the average person only three times. Sunscreens should also be used on cloudy days and applied about 30 minutes before going out in the sun and re-applied after swimming or towelling or after heavy perspiration.
- Clothing can also afford some sun protection depending on the degree of transparency of the material. The less transparent the clothing (when held up to the light) the greater degree of protection offered. An exception is T-shirts, which, when wet, offer less protection.
- The sun can damage the eyes, leading to the formation of cataracts and patients should wear sunglasses that offer UV protection.

Sun energies

The sun emits ultraviolet (UV) radiation in the range of 100-400nm in addition to visible radiation. The UV radiation is banded for convenience in to UVC (100-280nm), UVB (290-320) and finally UVA (320-400nm) with the longer wavelengths of light (380-770nm) representing the visible portion of the spectrum. Sunlight is composed mainly of UVA (as much as 90 per cent) with the remainder consisting of UVB radiation. Most UVC is filtered out by the ozone layer.

The effects on the skin of solar radiation can be divided into short-term and long-term:

- Short-term effects include sunburn, caused mainly by UVB as well as photosensitivity reactions such as polymorphic light eruption and solar urticaria, which are caused by UVA.
- Longer-term effects of the sun include premature ageing (induced by both UVA and UVB) characterised by coarseness, skin wrinkling, hyper (and hypo) pigmentation changes, solar elastosis (in which the skin becomes thickened with a yellowish tint) and telangiectasia (dilated and visible blood vessels) as well as skin cancers.

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A Science degree and some European language capabilities would be ideal, but not essential, whereas a willingness to undertake extensive overseas travel is a prerequisite for this position, as is the ability to create and maintain good relationships both with internal departments and with external suppliers.

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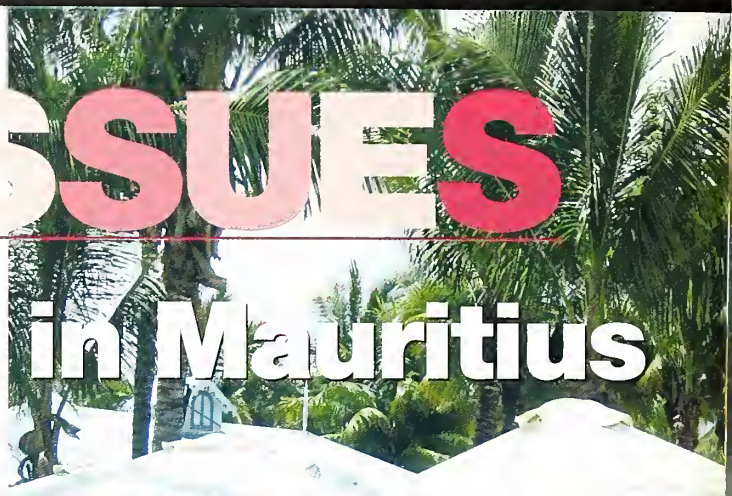

There was a soupçon of opportunity to relax during the Numark Conference in Mauritius, as Charles Gladwin discovered

The Numark conference started with confusion: as we touched down, the flight information screen on the plane said 31 – for those of us who thought it meant the date we were in for a shock as it was actually the temperature – at 8am on the last day of January. Was it wishful thinking to hope the same happy coincidence would not occur on our return to the UK on February 6?

Mauritius is an attractive island. We found out why it was so verdant later in the week as a tropical depression out in the Indian Ocean reminded us of its presence. But it is also a strange island – very flat in the middle with Jurassic Park peaks in small ranges round about (although the volcanic island is not that old).

The extensive fields of sugar cane – unfortunately a declining industry for the islanders – did prompt some to question what contribution Mauritius has made to global diabetes levels, though.

Numark had negotiated 'all-inclusive' facilities at the Sugar Beach Resort, so many happy hours were spent networking. The bar in the centre of the pool was, for some reason, rather popular. Unfortunately cocktails were not part of the deal: was a bill for 19 pina coladas on one account the record?

Eating places were frequented by a range of entertaining wildlife – mynah birds and muesli-eating sparrows at the main poolside restaurant and the cute family of tendrac of La Citronella. And was it really at this restaurant that Lord Fowler, member of Mrs T's Cabinet and former shadow home secretary, but who started his career on *The Times*, was asked: "So have you been a journalist all your life?"

Lord Fowler let on that, while secretary of state for health, his minister and junior minister had been John Major and Edwina Currie. As he put it: "We were a close knit team ... and the answer to your question is 'No, I didn't'."

His presentation looked at ways to go about raising awareness of your cause. Where he found that picture of someone resembling David Wood in a Batman costume – on a balcony at Buckingham Palace? – is quite a mystery.

Other quips made in the course of the business sessions (yes, this was a working trip) included Emeritus Professor Ian Jones leading an hour-long debate on the new contract. "If you're wondering what 'emeritus professor' means, it's 'job seeker'," he explained.

Raising doubts about his audio-visual presentation skills, he said there was "high tech and low tech, and then there's no tech". This might be explained by his reading matter: "In my hours of relaxation, I like to read old copies of the *Pharmaceutical Journal*. And I take the *Drug Tariff* on holiday."

Meanwhile, what could John Blenkinsopp have meant in relation to the deals available on generics? He told the apocryphal tale of the pharmacy contractor showing friends round his home: "And here's the fluoxetine wing, and this is the omeprazole conservatory..."

Job-seeker Jones, with an eye on clawbacks, commented: "That's all right so long as they don't have to dismantle the conservatory and send it back to Whitehall."

A day at the Domain du Chasseur, a mountain-top retreat, found a crowd of supporters of the local vanilla-flavoured rum. So good was it that the community singing – surely not led by NTL? – resounded off the hillside while others waited to see the sensitive and rare Javan deer that have their home in the park. And boy, did that venison curry taste good. "More Bambi, anyone?" No wonder dodos are extinct.

In fact all the food was excellent – as was the hotel and its staff. If there's a word to describe Mauritians, it's "smiley", they are so friendly and helpful. It was rather nice, then, that they arranged for the rain to hold off after the gala dinner so we could all leave the marquee (on the croquet lawn, don't you know) for the beach. There we watched a firework display sponsored by Teva UK, the company's name ablaze while Vivaldi's *Four Seasons* played over the palm tree loud speakers. Clever Teva.

It was great, too, to see Diane Norris, widow of former chief executive Terry, catching up with all her friends from former conferences. But most of all, well done to the Numark team for organising such a memorable conference. And for dealing so well with the vagaries of Air Mauritius's limited fleet (what's that about getting parts for our plane languishing in Geneva?).

That extra night's stay was as if the island didn't want us to leave.

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